
AN EXPLORATION OF SCHEMA MODES IN BIPOLAR DISORDER

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ABSTRACT

Schema Therapy (ST; Young et al., 2003) was developed for working with individuals who experienced complex psychological difficulties and patterns of relating, and who were not responding to traditional CBT. Developed originally for those with a Borderline Personality Disorder diagnosis, ST, which includes schema mode work, has more recently been expanded for use with other populations. Research has begun to explore the potential relevance of ST to those with a Bipolar Disorder diagnosis. However, currently there is a gap in the research exploring the descriptive value of the schema mode construct for this population. As a pilot study, this original thesis aimed to qualitatively explore participant's responses to Young Klosko and Weishaar's (2003) original schema modes and to what extent their experiences were consistent or distinct from descriptions of these.

Seven adults with a diagnosis of Bipolar Disorder took part in a semi-structured interview. They were presented with eight cards, each displaying a description of one of Young, Klosko and Weishaar's (2003) schema modes. Participants were then asked questions about each mode, which were based on a theoretical understanding of how modes are thought to operate. Interviews were transcribed and qualitative data was organised into eight matrices, one for each schema mode. Data were analysed for each matrix using Thematic Analysis.

Being demanding of oneself, self-criticism, anger and feeling separate to others appeared common themes across the sample. Difficulty regulating intense emotions was also highlighted. Stigma was identified as a factor which may influence some of these experiences. Whilst participants related to most of Young's mode descriptions and described emotional and behavioural states that were consistent with these, themes from the Thematic Analysis also highlighted shared experiences across the sample that were not encompassed by Young's descriptions of schema modes and how they are theorised to operate. Findings suggested that some of the thoughts, feelings and behaviours consistent with Young's modes, might be experienced more intensely in particular mood states. Such experiences might be prolonged through the use of avoidance or rumination as a way of coping.

The findings from the study were critically considered in relation to exploring the descriptive value of schema modes, which has not been done before. Limitations of the study were also discussed. Recommendations were made for future research in this area, and the clinical and societal level implications of the research findings were presented.

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1. INTRODUCTION

This chapter critically examines how Bipolar Disorder is typically understood and the theories relating to its causes. This provides the reader with a background to the potential relevance of Schema Therapy (ST) to this population. A review of the evidence base for ST and schema modes is then provided. The chapter concludes with a rationale for exploring schema modes in Bipolar Disorder and presents the research questions.

1.1. Literature Search Strategy

A narrative review of relevant literature is presented. In order to comprehensively review literature relevant to Bipolar Disorder and the evaluation of ST, electronic searches were conducted using EBSCOHost, (PsycINFO, PsychArticles, CINAHL Plus, Academic Search Complete), ScienceDirect and SCOPUS databases. A phrase search was used and search terms were refined through 'title' and 'subjects' within PsychINFO; and 'abstract', 'title', and 'keywords' in Science Direct. Search terms constituting advanced searches were aligned to the research questions and included 'early maladaptive schema' 'schema modes', 'Bipolar Disorder' and 'mania'. No date parameters were set. Following an initial screening of abstracts of the generated literature, the most relevant literature was selected for inclusion in the review. Additional relevant literature was identified from reference lists secured through the above searches and through google scholar. A search was also conducted of literature written by researchers known to contribute to this area. A total of seven papers specifically relevant to Bipolar Disorder and ST were retrieved.

1.2. Terminology

Throughout this thesis, I refer to individuals with a *diagnosis* of Bipolar Disorder (abbreviated to BD) as opposed to individuals *with* Bipolar Disorder. The latter assumes the presence of an underlying medical illness. However, I take the position that functional diagnoses are reductionist and reinforce biomedical assumptions about 'madness', which can prevent understanding of what is going on in people's

lives. Substantial evidence highlights the significant role that external factors such as social circumstances, trauma and abuse have in the development of psychological distress (Johnstone et al., 2018).

Boyle (2002) has argued that functional psychiatric diagnosis lacks reliability and validity. This chapter will demonstrate that indeed the 'Bipolar Disorder' construct fails to demonstrate validity in terms of symptomology and response to treatment. As much of the research uses these terms and categorisation by diagnosis has dominated the research agenda, the BD diagnosis has been used within this study to be comparable with existing research. However, this is not intended to be taken as indicating the existence of an underlying 'disorder'. There are a multitude of ways of understanding experiences and not every individual will accept the term 'Bipolar Disorder' as an accurate description of theirs.

1.3. Bipolar Disorder

The following section defines BD and outlines experiences typically associated with the diagnosis. Theories regarding the aetiology of these experiences are explored, some of which provide context for the potential relevance of ST for this population.

1.3.1. Deconstructing Bipolar Disorder

The term 'Bipolar Disorder' (BD) is used to describe patterns of extreme disruption to mood, behaviour and thought that occur throughout a person's lifetime (Saunders & Goodwin, 2010). The way in which extreme disruptions to mood are commonly understood has largely been influenced by two major diagnostic schemes: The DSM-V (Diagnostic Classification System; American Psychiatric Association, 2013) and the ICD (International Classification of Disorders; World Health Organisation, 2016), both of which contain similar definitions. Typically, a diagnosis of BD is given when disruption to mood follows a cyclical pattern of relapse into episodes of severe depression and (hypo)mania, with interweaving periods of relatively stable mood. Episodes of disrupted mood last several weeks, and do not usually follow a predictable course (British Psychological Society; BPS, 2010).

Mania is an intense disruption of mood, which has been associated with increased well-being and optimism. However, aspects of mania may be problematic, as people

often experience increased irritability towards others and a tendency to behave impulsively or make unwise decisions that impact on work and relationships (BPS, 2010). Mania can also involve experiences typically labelled as 'psychotic', where a person may lose touch with reality, hear and believe things that others do not, or make grandiose and unrealistic plans. Experiences of mania are characteristic of a Type-I BD diagnoses, whereas less extreme episodes of mood disruption (termed hypomania), typically result in a Type-II BD diagnosis. Experiences of depressed mood are common to each and people often spend more time depressed than manic (BPS, 2010).

Whilst the use of medicalised language such as 'episode' implies that manic, hypomanic, and depressed states can be clearly distinguished from each other, evidence suggests that in reality experiences are much more complex and mood states are overlapping. Approximately 40% of people experience 'mixed affective states' (where features of mania and depression are present in the same time period), or rapidly alternating moods (Shim, Woo, & Bahk, 2015). People might, for example, have grandiose beliefs whilst also feeling that others are trying to persecute them; or experience restlessness, agitation, and suicidal thoughts (BPS, 2010). Additionally, there is considerable evidence to suggest that people continue to experience low mood and anxiety between major episodes and that this continues to cause distress and impact on day-to-day functioning (Judd et al., 2002).

Functional diagnosis also implies that BD is a discrete condition, clearly distinguishable from other psychological problems and from 'normal' experiences of mood instability. However, there is considerable overlap between problems that have been labelled as BD and those that have been given other labels. For example, over a fifth of those diagnosed with Borderline Personality Disorder (BPD); a diagnosis characterised by mood instability, paranoia, impulsivity, and interpersonal difficulties, also have a co-morbid diagnosis of BD (Frías, Baltasar, & Birmaher, 2016). Additionally, there is good evidence to suggest that both depressive and hypomanic traits range on a continuum with the general population (e.g. Jones & Bentall, 2006). The BPS argues that as opposed to diagnosing people in an 'all-or-nothing sense' about their ability to regulate mood, the degree to which any person is able to do this ought to be seen on a continuum (BPS, 2010).

1.3.2. Prevalence

Uncertainty regarding the boundaries of the bipolar spectrum is reflected by a large disparity in estimated prevalence rates (Bebbington and Ramana, 1995). However, a world mental health survey identified a prevalence rate of 2.4 % across 11 countries (Merikangas et al., 2011), with comparable rates between men and women and an inverse relationship with age. However, the breadth of the bipolar spectrum and overlap between diagnoses may result in BD being over diagnosed, or individuals being inappropriately given another diagnostic label (Singh & Rajput, 2006).

1.3.3. Impact on functioning

BD is ranked by the World Health Organisation (WHO) as one of the top ten causes of disability (Sanchez-Moreno et al., 2009) and is associated with high rates of physical health problems (Kilbourne et al., 2009), occupational and marital difficulties (Dore & Romans, 2001; Marwaha, Durrani & Singh, 2013) and suicide attempts (Kogan et al., 2004). Research suggests that those with a BD diagnosis often have a reduced social network and that this is often accompanied by feelings of guilt or shame (Goodwin & Jamison, 1990). It is not only symptoms of BD that impact on functioning, but experiences such as poverty, social adversity, homelessness and the stigma associated with having a mental health diagnosis (Mileva, Vázquez, & Milev, 2013; Thornicroft, 2006).

1.3.4. Aetiology

BD has largely been considered a biological illness and research attempting to demonstrate a genetic predisposition has dominated the research agenda. Twin, family, and adoption study data suggests that BD may be inherited (e.g. Kieseppa et al., 2004). However, research has failed to make links between BD and specific genes. Any genetic markers have also been associated with Schizophrenia (Berrettini, 2004). Additionally, researchers have critiqued the results of genetic studies and their methodology (e.g. Joseph, 2006; Joseph, 2011). Often, findings lack consistency and cannot be replicated (Kato, 2007).

There is increasing acknowledgement that biological processes alone cannot account for differences in the onset, course and expression of BD symptoms. This has led to the incorporation of psychosocial factors in BD research, some of which are presented below.

1.3.4.1. The role of childhood adversity

A growing body of research suggests that experiences of childhood trauma modulate the course and expression of BD. Early abuse has been associated with earlier onset of difficulties, increased likelihood of 'psychosis' in BD and more emotional instability between major mood disruptions (Daruy-Filho, Brietzke, Lafer, & Grassi-Oliveira, 2011; Etain et al., 2013; Larsson et al., 2013). Among trauma subtypes, emotional abuse in particular has been found to have a dose-effect on the age of onset of BD by lowering the threshold for developing problems with emotion regulation (Li et al., 2014; Post et al., 2015).

Martins et al., (2014) found that emotional abuse is a risk factor for a number of mental health difficulties characterised by emotional instability including major depression, anxiety, BD and BPD. Early emotional abuse has been found to predict higher severity scores on measures of depression, hopelessness, anxiety and impulsivity; and has been linked to interpersonal sensitivity and impulsive hostility in BPD, and in manic and mixed bipolar states (Goodman et al., 2003; Garino, Gunawardane, & Goldberg, 2008).

At a biological level, adverse events in childhood are thought to increase the risk of BD by increasing the volatility of emotional states (Glaser, Van Os, Portegijs & Myin-Germeys, 2006). Childhood adversity and attachment difficulties have been found to predict aberrant hypothalamic-pituitary-axis (HPA) functioning and stress related brain changes such as increased amygdala activation and changes to the prefrontal cortex (Aas et al., 2012; van Harmelen et al., 2013). These areas of the brain are implicated in emotional dysregulation and impulse control respectively, perhaps highlighting a relationship between childhood trauma and problems with affect regulation.

The finding that childhood emotional abuse and neglect represent specific risk factors for BD is consistent with attachment theory and the idea that parental responsiveness shapes emotion regulation strategies and patterns for relating to others in later life (Cassidy, 1994). Attachment theory states that infants develop internal working models (IWM's) through interactions with early caregivers that provide implicit rules for understanding the self in relation to other and shape one's life experiences (Edwards & Arntz, 2012). Childhood adversities can impair the

quality of IWM's and the ability to form those secure attachments which enable healthy emotional functioning. Research into attachment histories of those with diagnoses of depression or BD has found insecure attachment relationships and parenting styles characterised by low maternal warmth, negative psychological control (e.g. criticism, intrusiveness and guilt-induction) and overprotection (Neeren, Alloy, Abramson, Pieracci, & Whitehouse, 2008; Rosenfarb, 1994). This 'affectionless control' style of parenting (Parker, 1983) has been found to contribute to negative cognitive styles characteristic of BD such as self-criticism (see section 1.3.4.4.). This suggests that interactions with caregivers may be internalised and become representations of the self and other (Parker, 1993).

Insecure attachment relationships have also been found to result in impaired mentalisation; the ability to relate to the emotional and intentional states of others (Slade, Belsky, Aber, & Phelps, 1999). This has been associated with the tendency to interpret hostile intentions to ambiguous situations in those with a diagnosis of BD (Lahera et al., 2015), which can significantly impact on functioning and relationships (e.g. Getz, Shear & Strakowski, 2003; Hofer et al., 2010). Together, insecure attachment and impaired mentalisation are considered underlying mechanisms for developing paranoia (Bentall et al., 2009), which is commonly experienced in BD (Raune, Bebbington, Dunn, & Kuipers, 2006).

1.3.4.2. Relationship between life events and extreme mood states

There is good evidence to suggest that stressful life events precipitate the onset and recurrence of extreme mood disruptions in those with a BD diagnosis (e.g. Christensen et al., 2003; Johnson et al., 2008). In a recent prospective study, 62% of a large sample of participant's experienced at least one stressful life event six months prior to relapse (Simhandl, Radua, König & Amann, 2015). Some theorists have suggested that this happens through destabilising circadian rhythms (biological cycles which govern sleep and activity levels) (e.g. Healy & Williams, 1989) and there is some, limited evidence to support this proposal (see Murray & Harvey, 2010 for a review of the evidence). A related hypothesis is that life events involving goal striving may trigger (hypo)manic episodes in those with a BD diagnosis by activating a hypersensitive neuropsychological system governing reward-seeking behaviour (the Behavioural Approach System (BAS); Gray, 1972). This is thought to result in extreme positive affect and motivation (i.e. mania) in relation to positive or goal

attainment events, and extreme negative affect and low energy (i.e. depression) in relation to events involving failure and non-attainment of goals. Evidence supporting this theory is extensive but mixed, and it has been critiqued by Power (2005) for being based on an overly simplistic understanding of emotions (see Power, 2005 for a review of the evidence).

Early adversity has also been found to predict chronic stress and reactivity to later stressful life events in those with a BD diagnosis (Gershon, Johnson, & Miller, 2013). A history of early abuse has been associated with increased likelihood of relapse into subsequent extreme mood episodes and the need for a longer period of recovery (Johnson & Miller, 1997). Importantly, current family functioning and environment have also been found to influence the course of mood disruptions and responses to stressful life events. Research into Expressed Emotion (EE; Miklowitz et al., 1988) has found that individuals living in environments that are hostile, critical and emotionally over-involved are more likely to experience relapse into mania or depression and make less gains from treatment (e.g. Barrowclough & Hooley, 2003). Those with early trauma histories may have fewer protective factors such as secure attachment and social support. This might then increase vulnerability to the long-term effects of early trauma and complicate the course of BD.

1.3.4.3. Cognitive processes

The majority of studies have found comparable cognitive styles across those with bipolar and unipolar depression diagnoses. Those with a BD diagnosis have been found to have a negative inferential style (i.e. the tendency to attribute negative events to causes that are internal (self-blame), engage in ruminative thinking, hold dysfunctional attitudes (e.g. around failure, loss and worthlessness) and have low or fluctuating self-esteem (Alloy et al., 1999; Reilly-Harrington, Alloy & Fresco, 1999; Jones et al., 2005; Scott & Pope, 2003). When implicit as opposed to explicit measures are used, these beliefs have been found to be sustained over time regardless of mood state (Alloy et al., 1999; Alloy et al., 2005; Lyon, Startup & Bentall, 1999). Substantial evidence now suggests that these negative cognitive styles mediate the relationship between early abuse and affectionless control parenting, and experiences of depression (e.g. Alloy et al., 2004, Gibb, 2002; for a review see Alloy et al., 2006).

Some research suggests that certain cognitive styles may be specifically relevant to those with a BD diagnosis. A number of studies have found that when compared to those with a unipolar depression diagnosis, those with a BD diagnosis in a euthymic¹ mood state have attitudes characterised by extreme goal/high achievement striving, perfectionism, high self-criticism and need for approval from others (Goldberg et al., 2008; Shapero et al., 2015; Strange et al., 2013). Perfectionism relates to holding excessively high standards for oneself and evaluating self-worth in terms of ability to achieve these (Shafran & Mansell, 2001); whilst relatedly, goal attainment beliefs refer to the desire to have positive affect and control over one's feelings at all times and the ability to excel at anything with enough effort (Lam, Wright and Smith, 2004). Perfectionism is also proposed to have developmental origins (Flett et al., 2002) and has been found to be associated with having overly critical, demanding and controlling parents (Bleys et al., 2016; Greblo & Bratko, 2014). Perfectionism and goal striving may then develop as survival strategies, designed to avoid criticism or seek acceptance where this need has not been met in childhood (Corbridge, Brummer & Coid, 2018). Some researchers suggest that extreme affective states are triggered when these specific cognitive styles interact with 'goal striving' life events and the hypersensitive BAS system (Johnson et al., 2005; Wright & Lam, 2004; Shapero et al., 2015).

Grandiosity, and at extremes, Grandiose delusions (GD's), have been found to be a key feature of BD (Tzemou & Birchwood, 2007). Such beliefs are centred around having inflated self-worth, knowledge or power (APA, 2013). One proposal is that GD's develop along with other symptoms of mania as a defence against the experience of depression and associated feelings of loneliness, powerlessness and failure (Beck & Rector, 2005). The finding that stable depressive cognitions have been found in those with a BD diagnosis on implicit but not explicit measures have mostly been interpreted as providing support for the 'manic defence' hypothesis of BD (Freeman, 1971).

Gilbert (2005) suggests that an inability to feel safe or soothed by attachment objects

¹ Euthymic refers to a 'neutral' mood, which by definition is associated with minimal symptoms. However, persistent vulnerability for mood dysregulation is always present (Kruger et al., 2003).

in infancy might lead to an elevated focus on social rank and status as a coping mechanism. Grandiosity then represents attempts to exert control over others by giving the impression of enhanced access to social resources. In their research, Mason et al., (2009) found a relationship between childhood abuse and delusions involving having special abilities, as well as those beliefs involving the self as defective. This perhaps supports the hypothesis that grandiosity develops as a defence against feeling inferior. Some research does indeed suggest that in the face of threatened social self-esteem or rank, defensive emotions and strategies such as GD's appear to be activated (e.g. Birchwood et al., 2006; Bentall, Kinderman, & Manson, 2005; Rhodes & Jakes, 2000).

In contrast to the manic defence hypothesis, in his extension of the cognitive theory of depression, Beck (1976) suggested that those prone to mania might also possess a set of positive self-schema, consisting of unrealistically positive attitudes about the self, world and future, which are triggered by elevated mood. In line with this and in relation to GDs, some theorists suggest that GDs are built on existing areas of raised self-esteem (e.g. Smith et al., 2005). Correlations have been found between higher explicit self-esteem and lower depression scores on self-report measures (e.g. Moritz et al., 2010; Fowler et al., 2006). However, it was not possible to determine the causality of the relationship in this research.

1.3.4.4. Limitations of cognitive research

In exploring the literature relating to cognitive styles in BD, it is noteworthy that research has been largely inconclusive as to whether relevant cognitive styles are specific to either depression or mania, or how they might be involved in the activation or escalation of extreme mood states (Alloy, Abramson, Walshaw & Neeran, 2006). Additionally, factors such as the dynamic and fluid nature of GD's, inter-episode mood instability, and the mixed affective states experienced by many with a BD diagnosis are largely overlooked by research. Many of the cognitive models are also limited by failing to take these factors into account, or by failing to adequately explain how individuals transition between mania and depression (Mansell, Reid & Tai, 2007). Whilst it is not to the purpose of this thesis to outline cognitive models of mood swings or contribute to literature theorising how they occur, the reader is

referred to Mansell, Reid and Tai (2007) for the most up to date model that endeavours to account for some of these issues.

1.4. Treatments for Bipolar Disorder

Research to date has mostly implicated the use of mood stabilisers such as Lithium in the treatment of BD (Goodwin, 2009) and pharmacological interventions remain the main focus of treatment guidelines (National Institute for Health and Clinical Excellence; NICE, 2014). However, increased recognition of the impact of stressful life events on the course of BD has led to the emergence of psychosocial interventions to be delivered in conjunction with medication. These have included psychoeducation (Colom et al., 2003); Cognitive Behavioural Therapy (CBT), which has largely focused on sleep and activity regulation, identifying triggers for relapse, and modifying behaviours and cognitions to prevent episodes becoming full-blown (Lam et al., 2003); Interpersonal and Social Rhythm Therapy (ISRT), which aims to address the impact of biological rhythms on reactions to events and relationships (Frank et al., 1997); and family therapy (Fredman, Baucom, Boeding & Miklowitz, 2015). According to a systematic review evaluating the effectiveness of available psychosocial interventions for BD, the largest evidence base is for CBT (Miziou et al., 2015). However, whilst there is some limited evidence supporting its effectiveness during the acute phase of bipolar depression, it has been found to lack utility for improving mania severity or psychosocial functioning between episodes (Miziou et al., 2015). Some researchers have argued that inconsistency in the effectiveness of CBT for BD is the result of an incomplete understanding of relevant cognitive styles (Lam, 2006).

1.5. The Need for Alternative Approaches

Whilst CBT is thought to have benefits for some individuals with a BD diagnosis, it is argued to be less well suited to more complex and long-term presentations (Miziou et al., 2015), which are arguably more commonly seen in mental health services. Leboyer and Kupfer (2010) argue that treatment is too heavily focused on alleviation of acute symptoms and preventing relapse, as opposed to treating the more

underlying and chronic associated difficulties. As highlighted in this review, trauma, abuse and insecure attachment is common in this population and can contribute to ongoing difficulties with emotion regulation, impulsivity, interpersonal difficulties and anxiety (see section 1.3.4.1.). Whilst cognitive theorists recognise the influence of early adversity on cognitive styles in depression, the effects of early abuse and insecure attachment have not yet been a direct focus of psychological interventions for BD.

The Power-Threat-Meaning framework (PTM) (Johnstone et al., 2018) has recently been developed to explicitly acknowledge the crucial role of adversity in the development of distress. This is based on the understanding that all humans have core needs and that anything preventing them from being met, such as trauma, abuse and insecure attachment, has the propensity to be experienced as a threat. According to this framework, 'symptoms' found to be common to numerous diagnoses may be recognised as responses to threat; developed to preserve self-esteem, maintain a sense of control or protect oneself from abandonment or rejection (Johnstone et al., 2018). Developing interventions that acknowledge the influence of adversity and directly address this in therapy might produce improved outcomes for some individuals with a diagnosis of BD. Schema Therapy (ST), as developed by Young (1990), is considered for further exploration in this research due to its potential to provide such an intervention.

1.6. Young's Schema Therapy Model (1990, 1999)

The following sections introduce Schema Therapy (ST), an extension of the traditional CBT model, and some of its theoretical origins. The key concepts of ST are described, including the role of Early Maladaptive Schema's (EMS), coping strategies and the development of schema modes in the conceptualisation of an individual's difficulties. In the following sections, a critical review of ST and its evidence base is also provided.

1.6.1. Origins

ST (Young, 1990; Young, Klosko, & Weishaar, 2003) was originally developed for individuals with complex patterns of relating and multiple psychological difficulties, who were not responding to traditional CBT. ST uses a cognitive behavioural

framework but expands on CBT by integrating aspects of attachment, psychodynamic and Gestalt schools of therapy. Compared to traditional CBT, there is more emphasis on exploring childhood origins of psychological problems, on working experientially with emotions, and on using the therapeutic relationship as a vehicle for change (Young, 1990). ST was designed to address the core psychological themes that are characteristic of longstanding difficulties, as opposed to managing acute symptoms (Young, Klosko & Weishaar, 2003). As such, it identifies and works with schemas originating in early childhood and continuing in adulthood.

Four main constructs are proposed: Early maladaptive schema (EMS), schema domains, schema processes and schema modes. Each of these will be discussed in turn.

1.6.2. Early Maladaptive Schema (EMS)

The prominent idea in ST is that psychological difficulties arise as a result of EMS. In broad terms, EMS are a set of cognitions, emotions, memories and bodily sensations developed during childhood that individuals rely on to make sense of themselves and their relationships. In order to develop healthy schema, Young, Klosko & Weishaar (2003) suggest there are core emotional needs that must be met during childhood including: Secure attachment to others, expression of needs and emotions, play and spontaneity, and realistic limits and autonomy. A number of early life experiences can obstruct these needs from being met, and it is these that foster the acquisition of EMS:

- Traumatisation or victimisation
- Toxic frustration of needs: A child's environment is missing something important (e.g. stability, emotional understanding, care)
- Internalisation of a carers destructive thoughts, emotions and behaviours
- A child is provided with e.g. excessive amounts of freedom, or parents are overprotective (Young, Klosko and Weishaar., 2003)

EMS severity is thought to lie on a continuum, influenced by the interaction between environmental and innate (e.g. temperament) factors. The most toxic and extreme experiences of childhood adversity are thought to result in the development of the

most extreme and rigid EMS, which are easily triggered and have severe and lasting consequences (Rafaeli, Bernstein and Young, 2011).

1.6.3. Schema domains

ST identifies 18 schemas, which each have their own origins and long-term impact. These are grouped into five categories of unmet emotional needs, termed 'schema domains'. For example, the *mistrust/abuse* schema relates to beliefs that one will be abused or taken advantage of by others and has typically been associated with trauma and victimisation in childhood. *Table 1.* provides a list of Young's EMS. Detailed descriptions of the 18 EMS can be found in Appendix A.

Table 1. Early Maladaptive Schemas (Young, Klosko & Weishaar, 2003)

<u>Schema Domains</u>	<u>Early Maladaptive Schemas</u>
Disconnection and Rejection	1) Abandonment/Instability 2) Mistrust/Abuse 3) Emotional Deprivation 4) Defectiveness/Shame 5) Social Isolation/Alienation
Impaired Autonomy and Performance	6) Dependence/Incompetence 7) Vulnerability to Harm or Illness 8) Enmeshment/Undeveloped Self 9) Failure
Impaired Limits	10) Entitlement/Grandiosity 11) Insufficient Self-Control/Self-Discipline
Other-Directedness	12) Subjugation 13) Self-Sacrifice 14) Approval-Seeking/Recognition-Seeking
Overvigilance and Inhibition	15) Negativity/Pessimism 16) Emotional Inhibition 17) Unrelenting Standards/Hypercriticalness 18) Punitiveness

1.6.4. Critical review of the EMS construct

Support for the schema construct comes from a range of studies over the past two decades which have used the Young Schema Questionnaire (YSQ; Young & Brown, 1990) to demonstrate that specific EMS are activated in a range of clinical populations (e.g., Halvorsen et al., 2009; Pinto-Gouveia, Castilho, Galhardo & Cunha, 2006) and that EMS vary in strength across clinical and non-clinical populations (e.g. Giesen-Bloo et al., 2006; Oei & Barnoff, 2007). The YSQ is a self-report measure used to measure presence, frequency and severity of an individual's EMS. This has been found by the literature to have sound psychometric properties (Schmidt, Joiner, Young & Telch, 1995; Lee, Taylor & Dunn, 1999).

Whilst based on an integrated understanding of a range of psychological theories and clinical observation, the theory of EMS development does arguably remain largely conceptual. There has been no attempt, for example, to specify connections between particular unmet needs and specific EMS (Flanagan, 2014), and there has been little exploration into *how* individual childhood abuse experiences might be internalised to lead to the development of EMS. However, evidence does show increased severity of EMS in clinical populations that have also experienced early adversity (e.g. Waller et al., 2001; Van Hanswijck de Jonge, Waller, Fiennes, Rashid, and Lacey (2003), and there is also evidence to suggest that EMS mediate the relationship between adverse childhood experiences and symptoms of some mental health difficulties (e.g. Calvete, 2014; Carr & Frances, 2009).

1.6.5. Schema processes

Young, Klosko & Weishaar (2003) suggest that maladaptive schemas are largely maintained through coping responses or schema processes, which also develop early in life to avoid the overwhelming emotions, cognitions, memories and bodily sensations that the activation of EMS produces. Maladaptive coping styles correspond to the basic threat responses (fight, flight and freeze). In the context of childhood, EMS represent the presence of threat (e.g. the frustration of one of the child's core emotional needs). Faced with threat, the child responds by overcompensating (fight), avoiding (flight) or surrendering (freeze). Whilst adaptive in childhood, coping styles become maladaptive with time as they perpetuate schema

and prevent the adoption of alternative ways of coping (Young, Klosko & Weishaar, 2003).

Schema surrender refers to a person's acceptance that the schema is true.

Unintentionally, the person repeats schema-driven patterns so that they continue to re-live the childhood experiences that created it. For example, a person may select a partner who is emotionally depriving and then relate to them in a passive way, which perpetuates the schema.

Schema avoidance refers to attempts to live without any awareness that the schema exists. This may involve blocking out thoughts and images that are likely to trigger it (e.g. through drug-taking), or attempts to arrange one's life so that the schema is never activated (e.g. avoidance of relationships).

Schema overcompensation refers to efforts to fight the schema by feeling, thinking and relating to others as though the opposite of the schema were true. For example, if a person felt worthless as a child, they may act in dominant ways as an adult. This leads to an underestimate of the power that the schema has on one's life (van Vreeswijk, Broersen, & Nadort, 2012).

1.6.6. Schema modes

Schema modes are the latest development in schema theory, defined as "moment-to-moment emotional states and coping responses – adaptive and maladaptive – that are currently active for an individual" (Young, Klosko & Weishaar, 2003; p. 37). These were developed as frequently, individuals would show rapid changes in feelings and behaviour that could not be explained by EMS (one-dimensional and stable trait-like constructs) (Lobbestael, van Vreeswijk & Arntz, 2007). Schema modes are the state-like, changeable manifestations of EMS. At any given time, it is suggested that some EMS and coping responses will be dormant, whilst others will have been activated by life situations and will predominate in a person's mood and behaviour. Those EMS and coping responses that appeared to be triggered together were amalgamated into schema modes to offer a more manageable alternative for working with shifting emotional states (Bamber, 2004).

Young suggests that every individual experiences a number of schema modes. For many, modes are well integrated and may be experienced like a mood, with seamless transitions between them (Young, Klosko & Weishaar, 2003). For others, modes may be experienced as more rigid and extreme, with rapid and abrupt shifts between them. Schema theory suggests that this is representative of dissociation between modes and can be associated with a 'fragmented sense of self' (Lobbestael, van Vreeswijk & Arntz, 2007). Maladaptive modes can reflect regression into intense emotional states experienced as a child, behaviours that mirror how the child was treated by a caregiver (reflecting an internalised parent), or an over developed coping method (Lobbestael, van Vreeswijk & Arntz, 2007).

Young and colleagues (2003) describe ten schema modes, which have been grouped into four broad categories: Child modes, dysfunctional parent modes, dysfunctional coping modes and the healthy adult mode. Termed in this way, they were designed to be accessible to clients and to enable associations between particular states of being and unmet needs in childhood. Each of the mode categories are described below. Descriptions of modes and their related EMS and coping style can be found in Appendix B.

1.6.6.1. Child modes

Child modes are considered to be innate, with all children born with the potential to develop them. If core needs were not met in childhood, dysfunctional child modes develop (*vulnerable, angry or impulsive child* modes). These modes are associated with intense negative emotions (fear, sadness, anger). A *happy child* mode develops if core needs were met in childhood and represents an absence of dysfunctional schema activation. Young suggests that the *vulnerable child* mode usually encompasses most of the core schemas (Young, Klosko & Weishaar, 2003).

1.6.6.2. Dysfunctional parent modes

These two modes reflect the internalised behaviour of parents or significant others (e.g. teacher, peer). The *punitive parent* mode is characterised by self-hatred, which might, for example, result from previous experiences of being punished for being 'bad'. The *demanding parent* mode is characterised by setting oneself excessively high standards (Young, Klosko & Weishaar, 2003).

1.6.6.3. *Dysfunctional Coping Modes*

The coping modes (*over compensator*, *detached protector* and *compliant surrenderer*) correspond directly to the three coping styles. Coping modes prevent the activation of painful child modes, but inadvertently perpetuate them (Young, Klosko and Weishaar, 2003).

1.6.6.4. *The healthy adult mode*

The *healthy adult* mode is a functional mode which performs three adult functions: nurturing and affirming the *vulnerable child*, setting limits for the *angry* and *impulsive* child, and moderating the dysfunctional parent and maladaptive coping modes. ST aims to strengthen this mode (Young, Klosko and Weishaar, 2003).

1.6.7. Critical review of the schema mode construct and its measurement

Research on the schema mode construct is limited, illustrating its relative infancy. Few studies to date have empirically tested its reliability and validity (see Lobbestael 2012, for a review). Mostly, studies have been centred on the development of the Schema Mode Inventory (SMI; Young et al., 2007). The short version of this form (Young et al., 2007) is commonly used in research and clinical practice to assess the presence of schema modes. This is a 124 item measure, which has demonstrated good psychometric properties and high internal consistencies for the identification of modes in personality disorder (Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010).

Using the SMI, correlations have been found between mode profiles theorised for BPD and the symptoms of BPD as assessed by the Structured Clinical Interview for DSM-IV personality disorders (Arntz, Klokman, & Sieswerda, 2005; Lobbestael, Arntz, & Sieswerda, 2005; Lobbestael, van Vreeswijk, & Arntz, 2008). Support for Young's hypothesised mode conceptualisations unique to specific personality disorder diagnoses have also been supported by more recent research (Keulen-de Vos et al., 2017; Bach & Farrell, 2018). Additionally, research has suggested that schema modes mediate the relationship between childhood trauma and dissociation, with a positive correlation being found between the number of modes identified using the SMI and levels of dissociation (see Johnston et al., 2009). Mood induction studies (e.g. Arntz, Klokman and Sieswerda, 2005; Lobbestael, Arntz, Cima & Chakhssi, 2009) have also provided some support for the theory that modes are

state-like experiences that respond to situational triggers. However, in these studies, the shifts between schema modes were not as extreme as young suggests. To date, there is a lack of further research providing insight into whether modes really do operate as Young, Klosko and Weishaar (2003) suggest, and how modes are associated with displayed behaviour and emotional responses (Lobbestael, van Vreeswijk and Arntz, 2007).

Although increased mode activation has been related to severity of distress and specific modes have been associated with certain personality disorders (e.g. Keulende Vos et al., 2017; Bach & Farrell, 2018), the main form of evidence for this comes in the form of high scores on the SMI. Smith (2017) argues that there is now a problematic reciprocal relationship between the theoretical understanding of modes and findings that have emerged from the use of the SMI (Smith, 2017). For example, on the basis of a reliability and validity exploration of the SMI, Panzeri et al., (2016) recently made claims that the theoretical structure of the ST model is strong, and that ST is therefore a promising approach for working with personality disorders. However, the SMI can be critiqued from both a conceptual and technical perspective. One must question, for example, how a single measure can reflect the situational triggering of a specific mode, whilst simultaneously assessing other modes characteristic of an individual and their underlying EMS 'traits' (Smith, 2017). Previous research has indeed shown the problematic nature of separating currently active modes from general modes on one instrument (Lobbestael, 2012).

Furthermore, some research has refuted the discriminant validity of schema modes, having found them to be significantly overlapping regardless of their category (see Smith, Bogue, and Conway, 2016). In their factor analysis, Smith, Bogue and Conway, (2016) found many of the so-called maladaptive modes to be significantly overlapping, as well as related to degrees of psychological well-being. They argued on the basis of their research that there is no evidence for the individual integrity of modes, as suggested by Panzeri et al., (2016).

It is also notable that in addition to problems inherent in the structure of the SMI, reliance on self-report measures in themselves can be limited. For example, individuals could under-report on experiences of particular modes through fear of judgment, lack of awareness, or rejection of these aspects of feeling and behaviour.

Indeed, researchers have found that some clinical populations appear to under-report the presence of modes when compared to their therapist's perceptions of whether modes are present (Lobbestael, Arntz, Lobbes, & Cima, 2009; Lobbestael, Arntz, & Sieswerda, 2005).

The above research demonstrates how the over-interpretation of an instrument such as the SMI in research might be problematic. Arguably, what also remains unclear from existing research, is whether a unitary score on an inventory can really reflect the multiple components of the mode construct. The limitations of mode research suggest that there may be a need for future research to use alternative methods to re-examine the theoretical structure of modes.

Despite possible limitations of the mode construct and its measurement, one qualitative study conducted on experiences of ST to date, found that the mode model was appreciated by service-users and therapists as it guided therapists in choosing appropriate techniques and gave service-users a recognisable frame to better understand their own feelings and responses (de Klerk, Abma, Bamelis & Arntz, 2017). This suggests that the mode construct may have clinical utility. However, research exploring service-user's perceptions of specific modes and how they are theorised to operate, is lacking. Given that modes were developed to make schema therapy more accessible to service-users, this is an apparent oversight in research to date.

1.6.8. Schema Therapy and mode work

ST interventions are focused on helping individuals to find adaptive ways of meeting their core emotional needs. ST takes a 'bottom up' as opposed to 'top down' approach, beginning by helping individual's to identify their EMS and associated emotions and coping styles (Young, Klosko & Weishaar, 2003).

ST also places emphasis on using the therapeutic relationship as a vehicle for change through two primary therapeutic strategies: limited re-parenting and empathic confrontation (Young, Klosko & Weishaar, 2003). In limited re-parenting, the therapeutic relationship is used as a secure base to meet core needs not met in childhood. Using a range of cognitive, behavioural and interpersonal techniques, the therapist assists the individual in combating EMS and empathically proposes

reasons for change when unhelpful patterns are repeated (Young, Klosko & Weishaar, 2003). The focus on childhood experiences using an attachment theory framework in ST (Bowlby, 1969) may be of particular interest to BD, since insecure attachment is common for individuals with this diagnosis (Morriss, van der Gucht, Lancaster & Bentall, 2009).

Schema mode work was originally developed as an advanced component of ST, designed for use when therapists felt stuck with clients who exhibited rigid avoidance and high levels of self-criticism and internal conflict (Young, Klosko & Weishaar, 2003). However, mode work is now increasingly used as the identification of modes helps to compose a useful and accessible formulation for individuals, which gives rise to specific goals and interventions (Fassbinder, Schweiger, Jacob, & Arntz, 2014).

In mode work, the therapist aims to enable the expression of needs and develops the individual's capacity to comfort themselves in more adaptive ways (Fassbinder et al., 2014). This is facilitated through the use of experiential techniques such as letter writing, imagery and empty chair dialogue work (Kellogg, 2004), borrowed from Gestalt and emotion-focused therapies. Therapists encourage the creation of visual representations of different modes and elicit dialogue between them. Using role play and modelling, the *healthy adult* mode is strengthened to enable self-soothing, and critical voices are externalised as separate to the self. According to Young (1990), the use of experiential techniques is more likely to increase lasting change through accessing areas of the brain where emotional memories are stored, such as the amygdala (LeDoux, 1993). This apparently facilitates a shift from knowing intellectually that the schema is false, to *feeling* that it is false.

Compared to traditional CBT, ST can be longer in duration because the aim of therapy is to address deeply entrenched schema (Young, 1999). Young, Klosko and Weishaar (2003) suggest that the presence of EMS may make working within a traditional CBT framework difficult for some individuals. For example, *abandonment* schemas, common to those who have experienced early trauma, may make it difficult to quickly establish the positive therapeutic alliance often necessary for short-term CBT. It is argued that such schemas are also better targeted by relational and experiential techniques (Young, Klosko & Weishaar, 2003).

1.7 Critical Review of Schema Therapy and Mode Work

1.7.1. Processes and techniques

1.7.1.1. Consideration of the focus on early adversity and EMS

An early focus on EMS in therapy has been argued to result in more comprehensive conceptualisations, which can better inform the therapist about the development and maintenance of problems, possible obstacles to change, and the potential need for structural changes in the therapy (e.g. pacing of sessions, number, length) (Young, Klosko and Weishaar, 2003). However, James (2001) highlights that there is little evidence to suggest that working with core beliefs is more successful for producing long-term change than working with more automatic cognitions or behaviours. By focusing on deep level schemas, some argue that there is an underemphasis on the use of traditional CBT techniques that can lead to more immediate change (see James, 2001). The suggestion that this might then delay relief from distress has led to questioning the clinical and cost-effectiveness of ST (e.g. James, 2001). In a recent qualitative study exploring participant's experiences of receiving ST, some did indeed report that they found the focus on past experiences to be unhelpful as they did not feel this related to managing their current situation (De Klerk et al., 2016). However, research suggests that for some service-users, understanding how the past is implicated in experiences of distress is a preferred emphasis for therapy (Valkonen et al., 2011). When to use ST over more traditional forms of CBT, and how this decision is made, is a continuing source of debate (see James, 2001).

It has also been argued by Flanagan (2014), that with the increased focus on attachment and object relation theories in ST and the related endeavour to identify corresponding parent and child modes, there has been a shift away from the broader agenda of unmet needs in general, which was the original aim of ST. Additionally, whilst STs grounding in attachment theory provides a shift away from individualising distress, it is argued that often 'blame' is shifted backwards in time towards parents, guardians, and teachers; rather than considering factors such as culture, gender and class and the impact that these wider systemic factors also have on ones developing sense of self (James, 2001). For some participants in the above mentioned

qualitative study, this was given as a reason for the discontinuation of therapy (De Klerk et al., 2016).

1.7.1.2. Consideration of power and use of the therapeutic relationship

A further critique in relation to the experience of ST lies in the consideration of power. ST focuses on how early deprivation and abuse can lead to the development of EMS and psychological distress (Young, Klosko and Weishaar, 2003). Arguably, underlying these factors is the experience of powerlessness, and overcoming and surviving the impact of early trauma is likely to involve regaining power and control (Proctor, 2008). One might then argue that the dynamics of manualised therapy and pre-defined constructs such as modes, which are based on Westernised assumptions, lead to the therapist having additional power. In ST's use of observational expert language and descriptions of service-user's expressions of coping as 'maladaptive modes', this framework arguably attempts to re-enact narratives proposed by the theory, as opposed to enabling genuinely self-authored narratives and ideas about the self to emerge (see Hedges, 2005).

Furthermore, ST uses the therapeutic relationship as a vehicle for change by working with the transference between the service user and therapist, and therefore also has its power-base located in the 'expert' of the analyst. Some of the challenges and unhelpful aspects of ST outlined in De Klerk et al., (2016), may be seen as arising from the power imbalance inherent in ST and techniques such as limited reparenting. However, there has been little research to date into how the therapeutic relationship is experienced by service-users with a history of trauma and how this contributes to ST outcomes.

1.7.2. Evidence base for Schema Therapy and mode work

Most research evaluating the efficacy of ST² to date has been focused around its use with BPD, for which it was originally developed. A number of large-scale Randomised Controlled Trials (RCT's) (e.g. Giesen-Bloo et al., 2006) and case-series (e.g. Nordahl & Nysaeter, 2005) have been used to evaluate ST in those with

² Some of the conducted research is based on the original ST model and does not include working with schema modes.

a BPD diagnosis and have provided some evidence for its efficacy. For example, in their study comparing ST to transference-focused psychodynamic therapy, Giesen-Bloo et al., (2006) found significant symptom reduction in those with a BPD diagnosis following ST. Additionally, those in the ST group had lower drop out rates and scored higher ratings on measures relating to therapeutic alliance.

ST is also gaining popularity for use with other populations. However, there is a paucity of good quality research in relation to other personality disorder diagnoses and mental health conditions. Taylor, Bee and Haddock (2016) recently carried out the first systematic review of the evidence for the effectiveness of ST in reducing EMS and improving symptoms across a range of mental health difficulties. They found that only twelve published studies met their criteria. Approaches to ST varied, with some including individual or group mode work (e.g. Arntz & van Genderen, 2009; Van Vreeswijk & Broersen, 2012).

11 of the 12 studies reported significant reduction in EMS and symptoms. Seven of these studies examined borderline and other personality disorders, with some using group ST with mixed personality disorder diagnoses (Renner, Arntz, Leeuw & Huibers, 2013; Skewes, Samson, Simpson & van Vreeswijk, 2015; van Vreeswijk, Spinhoven, Eurelings-Bontekoe, & Broersen, 2014) and mixed mood and personality disorder diagnoses (Videler et al., 2014). Results from the seven studies showed reductions in EMS and maladaptive schema modes, with significant medium to large effect sizes. In their review, Taylor, Bee and Haddock (2016) also found limited good quality evidence for ST and EMS and schema mode change in working with eating disorders (e.g. George et al., 2004; Simpson et al., 2010), PTSD (Cockram et al., 2010) and chronic depression diagnoses (Malogiannis et al., 2014).

Evidence for the effectiveness of working directly with modes also primarily exists in relation to BPD (Giesen-Bloo et al., 2006; Nordahl & Nysaeter, 2005). As mentioned in section 1.6.3., particular combinations of modes have been found to be characteristic of specific personality disorders (Lobbestael van Vreeswijk, & Arntz, 2007) and mode models for most personality disorder diagnoses have now been described (Lobbestael, van Vreeswijk, & Arntz, 2008). The mode concept has now also been expanded for use with forensic populations (Bernstein, Arntz, & de Vos, 2007), those with an obsessive compulsive disorder diagnosis (Gross, Stelzer, &

Jacob, 2012), eating disorders (Pugh, 2015) and chronic depression (Renner et al., 2013). However, research supporting mode models and the use of mode work to reduce symptoms in these populations is limited and tends to be presented as single case series (e.g. Simpson & Slowey, 2010).

Whilst evidence for the effectiveness of ST and mode work is clearly still in its infancy, research indicates that EMS may be associated with a range of difficulties and that targeting them in therapy through EMS and mode work can lead to symptom reduction. Notably however, good quality evidence for the use of ST with those other than with a personality disorder diagnoses is limited (Taylor, Bee & Haddock, 2016), and many studies have been based on finding from YSQ and SMI, which does have limitations (see section 1.7.7). Across published research there are also variations in methods for conducting ST, in the length of intervention, and in the way in which EMS are assessed and reported on, which makes findings difficult to interpret. Additionally, many of the reviewed studies have small sample sizes and lack comparison groups. Taylor, Bee & Haddock (2016) suggest that although current findings do suggest some potential utility for using ST with a range of clinical populations, they should be interpreted with caution.

1.8. The Potential Utility of Schema Therapy for Bipolar Disorder

Despite the potential limitations of ST and schema mode work that have been outlined, the recent application of ST to other populations where approaches such as CBT may not have been successful suggests that the ST approach may also have utility for those with a BD diagnosis. Advocates of ST have already argued that the model should be extended for those with a diagnosis of BD (Hawke, Provencher & Parikh, 2012). This has been based on the rationale that many individuals with a BD diagnosis have had toxic childhood experiences that complicate the course of BD (Garno et al., 2005) and that there are also a number of similarities between BD and BPD, for which ST has already been found to be effective (Giesen-Bloo et al., 2006).

As mentioned, there has been a paucity of research in this area. However, some research has begun to demonstrate high levels of specific EMS in samples of

individuals with a BD diagnosis. This research is presented below, along with a rationale for exploring schema modes in this population.

1.8.1. EMS and schema modes in Bipolar Disorder

1.8.1.1. EMS

A number of quantitative studies have now been conducted to explore the presence of EMS in those with BD diagnoses using the YSQ (Young & Brown, 1990). Previous research has found elevated scores on most EMS compared to non-clinical control groups and mostly comparable scores to those with a major depression diagnosis (Hawke & Provencher, 2012; Mehmet et al., 2011; Nilsson et al., 2016). In those with a BD diagnosis, higher EMS scores have been associated with more functional impairment (Nilsson, 2012), suggesting that further research into EMS and schema modes might provide insight into the characteristics and long-term course of BD.

Across the research assessing for EMS in BD, studies have consistently found significantly higher scores for three EMS in particular. Hawke, Provencher and Arntz (2011) found significantly higher scores on the *entitlement/grandiosity*, *approval/recognition seeking* and *insufficient self control* schemas, and a lower mean score on the *emotional inhibition EMS* in those with a hypomanic personality style compared to non-clinical controls. These same findings have been replicated in three other studies when comparing those with a BD diagnosis to those with a unipolar depression or anxiety diagnosis, after controlling for symptoms of depression (see Hawke & Provencher, 2012; Nilsson, 2012; Nilsson, Straarup & Halvorsen, 2015).

Recognising the shared clinical features of BPD and BD, one study compared EMS across these two groups. They found that all EMS scores were significantly higher in the BPD compared to the BD group and that the BD group only scored significantly higher than non-clinical controls on the *insufficient self control EMS*, with a trend towards higher scores on the *approval/recognition seeking* and *grandiosity EMS* (Nilsson, Jørgensen Straarup & Licht, 2010). This study was however limited by a small sample size.

It is notable that most studies have found largely comparable EMS scores across clinical samples regardless of diagnosis, which is perhaps unsurprising given that diagnostic categories have been proven to lack distinct boundaries and are overlapping. However, the EMS that participants with a diagnosis of BD have scored particularly highly on, does appear consistent with existing research into cognitive styles outlined in section 1.3.4.3.

Existing cognitive research has implicated perfectionistic cognitive styles and goal striving in the development and maintenance of BD (e.g. Lam, Wright & Smith, 2004). Consistent high scores on the *approval/recognition seeking* and *entitlement/grandiosity* EMS across studies may be reflective of this, as individuals might strive to achieve goals to obtain recognition from others (Nusslock et al., 2007). High scores on these EMS could be interpreted in the context of existing literature relating to attachment insecurity and social rank (see section 1.3.4.3). Additionally, there is some evidence to suggest that the *entitlement/grandiosity* EMS mediates the relationship between early emotional and physical abuse/neglect and experiences such as affective and interpersonal instability and anger, at least in a sample of those diagnosed with BPD (Varnaseri, Lavender & Lockerbie, 2016). This might support Young, Klosko and Weishaar's (2003) assertion that childhood factors such as 'toxic frustration of needs' and 'traumatisation and victimisation' foster the acquisition of EMS.

The *insufficient self-control* EMS is characterised by difficulty restraining emotions, distractibility and impulsivity, which are all characteristic of BD (Carver & Johnson, 2009). Taken together, the high scores on *insufficient self-control* and the low scores on *emotional inhibition* appear consistent with its emotional and behavioural intensity (Hawke, Provencher and Parikh, 2012). This could be understood in relation to the impact that adverse early experiences and insecure attachment can have on HPA functioning and the mind and body's ability to regulate emotions. Those with a BPD diagnosis also show high scores on the *insufficient self-control* EMS and report high levels of childhood abuse (e.g. Bandelow et al., 2005).

1.8.1.2. Schema modes

To date, no research has directly explored schema modes in BD or their possible relationship to mood states. However, Khalily, Wota and Hallahan (2011) have

compared SMI scores to scores on the Minnesota Multiphasic Personality Inventory (MMPI), which examines patterns of emotional and personality 'disorders'. Moderate to strong positive correlations were noted between the mania scale of the MMPI and the *angry and enraged child* modes and between the depression scale of the MMPI and the *detached protector* and *vulnerable child* modes. Whilst this might suggest the activation of particular modes during depressed or manic states, these findings were not specific to those with a BD diagnosis. The researchers also reported limited power, suggesting that potential significant relationships between mood states and other modes may not have been detected.

1.8.2. Rationale for exploring schema modes in Bipolar Disorder

The limitations of current psychological models and interventions for BD outlined in section 1.4. suggest a need to explore the potential of other approaches. As highlighted, many of those with a BD diagnosis continue to experience functional impairment, interpersonal difficulties, and emotion regulation problems between major mood episodes (Becerra et al., 2013), which current treatments for BD do not appear to adequately address. It is hypothesised that difficulties with affect regulation are a product of growing up in environments where significant others are unavailable or unresponsive to one's emotional needs (Young, Klosko & Weishaar, 2003). However, much of the literature and treatment for BD appears to be focused on assumptions of biological vulnerability and preventing relapse, as opposed to putting life experiences at the forefront of theories and addressing their ongoing impact.

Emotion regulation is central to the mode concept (Dadomo et al., 2016) and within ST, emotions are given primacy over cognitions in treatment (Young, Klosko & Weishaar, 2003). Mode work has been found to be effective for working with those experiencing emotion regulation difficulties, through linking these states to adverse early experiences as they arise in session. This is done whilst providing safe attachment and validation of needs and emotions through the process of limited re-parenting via the therapeutic relationship (Young, Klosko & Weishaar, 2003).

Although clearly more research is required to ascertain how techniques relating to the therapeutic relationship are experienced by service users (see section 1.7.1.2.), existing research suggests that ST and mode work could also be beneficial for

working with those with a BD diagnosis, given that their unmet needs are likely to have origins in attachment relationships that were abusive, neglectful or inconsistent.

Psychological understandings of BD are limited but developing (see section 1.3.4.4.). There is some evidence to suggest that particular cognitive styles may be relevant to those with a BD diagnosis and this appears consistent with high scores on related EMS. However, it is unclear which of these are activated in particular mood states (including mixed affective states), what might trigger them off, or their possible contribution to both extreme mood states and the more chronic difficulties associated with BD. An initial exploration of schema modes across mood states may contribute to developing current understandings of BD, as well as ascertain whether future research into the utility of ST for those with a BD diagnosis would be worthwhile.

ST is demonstrating some promising findings regarding its effectiveness for reducing levels of distress through EMS and schema mode change in other populations. This suggests that ST could also have utility for those with a diagnosis of BD. However, mode models acting as therapy ‘formulation’ models for different diagnostic groups have been developed almost solely through quantitative research and have been based on high scores on the SMI, which has a number of limitations (see section 1.6.7.). To date, service-user’s responses to schema modes and the extent to which mode descriptions (including their theoretical structure and operation) correspond with their experiences of distress and coping, has yet to be explored. Given that schema modes were developed to increase the accessibility of ST for service-users (Young, Klosko and Weishaar, 2003), exploring the descriptive utility of the schema mode construct would appear a necessary preliminary step towards ascertaining whether ST could offer a useful alternative for working with those with a BD diagnosis.

1.9. Aims and Research Questions

The overall aim of this piece of initial exploratory research was to examine the descriptive value of schema modes through the following two research questions:

- 1. How do participants respond to descriptions of schema modes?*
- 2. How do participants perceive the relationship between schema modes and bipolar mood states?*

2. METHODOLOGY

This chapter will describe the research methodology, epistemological position taken and the rationale for undertaking qualitative research using Thematic Analysis (TA). The procedure used to carry out the study will then be described, followed by an account of how the analysis was conducted.

2.1. Epistemological Positioning

This research was approached from a critical-realist epistemological stance, which is neither objective nor constructionist in ontological positioning. In order to produce knowledge that can make a difference, one must assume existence of some knowable reality (Stainton Rodgers & Stainton Rodgers, 1997). The critical-realist paradigm requires belief in an independent reality, but does not commit to one absolute knowledge of it (Scott, 2005). Instead, it acknowledges that what is ‘real’ lies behind the subjective and socially influenced lens of both the researcher and participant, and that it is only this that can be accessed (Willig, 2013). From a critical-realist stance, any knowledge claims should submit to extensive critical examination.

The way in which BD is understood, spoken about and experienced is constructed within a broader social, cultural and historical context. Schema modes are also acknowledged to be concepts that have been developed within a particular context (i.e. the context of therapeutic practice). Therefore, instead of aiming to prove the existence of schema modes or propose that modes represent a ‘true’ reflection of how people’s experiences are clustered together, I have instead sought to gain access to several different subjective stories about the experiences of individuals with a diagnosis of BD, and how schema mode descriptions are received by them. It is acknowledged that these have been created from the shared experiences of the participant’s and myself, and that I have interpreted such stories through my multiple positions as a researcher, psychologist and individual with personal beliefs and experiences. A reflexive stance was therefore taken throughout the research process to increase awareness of the impact of my own truths, knowledges, and theoretical perspective on observations of the data (see section 2.4).

2.2. Use of Qualitative Methodology

2.2.1. Rationale for using qualitative methodology

To date, research exploring the potential relevance of ST to those with a diagnosis of BD has typically focused on employing quantitative methods to examine the relationship between EMS and symptoms associated with BD using the YSQ (Young et al., 2007). Schema modes have not yet been examined in this population. From a nomothetic perspective, modes would not be seen to exist until they are validly measured in a large population. Whilst a quantitative study relying on the use of the SMI might produce data from a larger number of cases, the aim of this research was not to try to prove the existence of modes, but rather to offer a first preliminary step to exploring the potential value of the mode construct to this population.

Furthermore, reliance on quantitative methods for data collection would mean that the idiosyncrasy of any particular case would be oversimplified. For example, whilst two individuals might have a similar SMI score, subtler aspects of an individual's conflicts would be ignored. The design of this study was then considered both in relation to the critique of the SMI outlined in section 1.6.7. and the question of whether the theoretical structure of modes has yet been empirically supported (Smith, 2017).

Based on the study's epistemological positioning and research aims, a qualitative design taking into account the contexts in which experiences are rooted (Robson, 2002), was deemed most appropriate. This appeared particularly relevant, as although modes were developed to increase the accessibility of ST for service-users and therapists, there has been no qualitative research into schema modes to date. As clinicians are expanding the use of ST in practice, exploring the descriptive value of the mode construct (i.e. to what extent mode descriptions capture participants' experiences) for this population could have some utility.

2.2.2. Considered use of triangulation methods

The original research proposal for this study incorporated use of the SMI as a secondary investigative tool alongside qualitative analysis. It was initially considered whether SMI scores might be used as a comparator to participant's accounts of modes during interview to enrich data collection, and potentially provide additional insight into how particular modes might correspond with mood states. It should be

noted however, that although participants did complete the SMI following the interview as per the original research and ethics proposal, the decision was made not to include this data as part of the final analysis and write-up. Given the study's research aims, it was felt that using the SMI data could undermine the exploratory nature of the study and detract from participant's accounts of their lived experiences. Furthermore, the unavoidable recruitment of participant's who differed vastly in their reported mood state meant that the SMI data could not have been used robustly for its original intended purposes. Given that the SMI data was collected, a description of the self-report measure and participant's SMI scores are made available to the interested reader in Appendix C. This is accompanied by a commentary on discrepancies between participant's SMI scores and their reported experiences during interview. This data should be viewed as a standalone appendix and as separate to the presented research study.

2.3. Thematic Analysis

Thematic analysis (TA) was selected as the method of qualitative analysis, based on its consistency with the study's research aims. Interpretive Phenomenological Analysis (IPA) was also considered. IPA aims to achieve an in-depth and robust examination of idiographic and contextualised accounts, and the development of themes are purely driven by the data and the meaning attributed to an individual's lived experience (Smith & Osborn, 2008). In this research, superordinate themes were pre-defined (i.e. schema modes) and analysis was predominantly led by ST theory. Therefore, TA was selected as a more flexible approach to analysis which can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2013). TA is described as the most transparent and systematic type of qualitative analysis as it reveals the prevalence of themes without forgoing depth of analysis (Joffe, 2012).

The approach to analysis in this study was primarily deductive, as it was driven by pre-existing theoretical knowledge of schema modes. However, flexibility was maintained to enable the generation of new themes from the data, which were independent of pre-existing theory. Allowing for unanticipated findings enables the

researcher to flexibly examine how individuals make sense of their experiences and the broader context that is imposed on these meanings (Braun & Clarke, 2006).

TA can involve the observation of thematic patterns at the semantic, or latent level of meaning (Boyatzis, 1998). It was appropriate to approach the analysis at both levels. The first stage of analysis (see section 2.8 for stages of analysis) took a semantic approach, focusing on surface-level meaning in order to organise data into schema mode categories. Following this, the analytic process involved progression to interpretation at the latent level, where there was an attempt to theorise the significance of the semantic patterns and their broader meanings and implications (Patton, 1990).

2.4. Researcher Reflexivity

It is not possible for any researcher to remain outside the subject they are researching and impartial to the generation of data (Willig, 2001). Reflecting on preconceptions, values, assumptions and biases that might impact on the research process is therefore an essential requirement for good qualitative research (Yardley, 2000).

Efforts were made to remain reflexive throughout the research process from the generation of initial ideas to the thesis submission. For example, I considered my own beliefs about diagnosis and the BD construct, which has been influenced by my own family's experiences of mood related difficulties, as well as my clinical psychology training at UEL. I also reflected on my position as a Trainee Clinical Psychologist (TCP), who although not trained in ST had experience of working therapeutically with individuals with a BD diagnosis. I considered how both my personal and professional experiences might lead me towards making uncritical generalisations or preconceptions about the relevance of schema modes to this population, or about the relevance of some modes over others. I kept a note of these reflections during the research process in order to limit confirmation bias, as I was aware that my preconceptions had the potential to influence the questions that I asked and the prompts that I used. In relation to this, I was also aware that my own inexperience with ST might make me more reliant on my field supervisors knowledge

and experience and that I might be influenced by his beliefs, biases and assumptions about ST.

It is also noteworthy that this piece of research was designed alongside another research project exploring schema modes in psychosis, which was carried out by another UEL TCP. I reflected on how we might influence each other's assumptions and how assumptions that are shared may be harder to identify and reflect upon. A critical review of my position as a researcher is further addressed in chapter four.

2.5. Recruitment and Sample

2.5.1. Recruitment

Participant's were recruited from four Community Mental Health Teams (CMHTs) within one inner London NHS Trust from whom research approval had been granted. Suitable participants were identified by professionals working in these teams and included Care Coordinators, Clinical Psychologists or other team members involved in their care. Members of the care team were given information sheets to read (Appendix D), and were asked to identify potential participants from their caseloads using the inclusion criteria. Staff were then asked to give those who expressed an interest in participating verbal and written information about the study (Appendix E). If potential participants expressed an interest, they were asked for their consent for me to contact them with more information about the study. Research interviews were then arranged with those who expressed a continued interest in participating following our initial conversation.

2.5.2. Inclusion criteria

English-speaking adult participants with a diagnosis of Type-I BD were recruited. This diagnosis was used in an effort to increase the homogeneity of the sample and interview people who had likely experienced extreme mood states that were clearly distinct from one another. Additionally, it was thought that those with a Type-1 diagnosis would be more likely to be under the care of CMHTs, whilst those with a Type-II BD diagnosis might be more likely to reside within primary care services. Participants were not accepted to take part if they had any other co-morbid mental health diagnoses apart from anxiety, given its prevalence. All participants had to be considered by their care team to be well enough to take part in the study and

able to give informed consent.

The sample was homogenous to the extent that all participants had a Type-1 BD diagnosis, but they varied in their mood state at the time of interview (see Table 2.). Given that the research was exploratory, there were no theoretical grounds for restricting the sample by mood state. Mood state at time of interview was self-reported and judged to be consistent with my own observations and those of the recruiting clinician. To avoid restricting the sample, homogeneity of characteristics (e.g. gender) was not sought.

2.5.3. Sample

Braun and Clarke (2013) suggest that in order for saturation of the data to occur, the minimum number of participants for a small-scale research project using TA should be six. Seven participants took part in the research in total. An eighth participant was briefly interviewed, however, her data was excluded from the analysis for two reasons: Firstly, she had a Type-II diagnosis and therefore did not meet the inclusion criteria and secondly, it was not possible to maintain focus in interview and complete all of the questions in the time frame.

Five of the participants were female, and two were male. Their ages ranged from between 31 and 58 years old and they self-reported a diverse spread of ethnic backgrounds. Participants self-reported the age at which they were given a BD diagnosis (mean = 22 years). All participants had experienced at least one previous acute episode of mania resulting in hospitalisation. A summary of participant demographics can be found below in *Table 2*. It is noteworthy that one participant (Amy) had historically suffered a brain injury. However, neither Amy or her psychologist felt that this had resulted in changes to the experiences she associated with her BD diagnosis. Her data was therefore included in analysis.

Table 2. Participant demographic details

Name *	Gender	Age	Ethnicity	Age of Onset	History of Therapy	Mood State
Sharon	Female	58	White-British	25	Yes	Euthymic
Zehra	Female	42	Declined to answer	35	Yes	Low-Euthymic
Eymen	Male	39	Turkish-British	20	Yes	Low
Michael	Male	45	Black-British	18	No	Euthymic
Basima	Female	31	Bangladeshi-British	18	Yes	Euthymic
Lucy	Female	41	White-British	21	Yes	Low-Euthymic
Amy	Female	35	White-British	21	Yes	Hypomanic

**Each participant was assigned a pseudonym to maintain confidentiality*

2.6. Ethical Issues

Ethical issues that could arise were considered with reference to the British Psychological Society's (BPS) code of human research ethics (BPS, 2014).

2.6.1. Ethical approval

NHS ethical approval was obtained (see appendix F). UEL ethical approval was not required.

2.6.2. Informed consent

Prior to the commencement of the interview, participants were given the opportunity to re-read the information sheet. They were then asked if they had any questions, before signing the consent form (Appendix G). This form stated that participants were free to withdraw from the study at any time without this impacting on their care.

2.6.3. Confidentiality and anonymity

Demographic information and interview data were kept confidentially. Participants

were informed that confidentiality would only be breached if there were concerns for the safety of themselves or others, and that all efforts would be made to discuss this with them first.

All audio-recorded interviews, transcripts and questionnaire responses were saved on a password-protected computer in separate password protected files, with each interview given a unique code. All interviews were transcribed by the interviewer and participants were made aware that any identifiable information would be altered in transcripts and thesis extracts to preserve anonymity. Participants were informed that thesis supervisors would have access to extracts from transcripts to assist with the process of data analysis. The audio files were deleted from the audio recorder after being uploaded. Typed transcripts will be kept on a password protected computer for five years and will be destroyed after this time.

Paper-based versions of the above documents were kept in a locked environment, only accessible by myself. Consent forms were stored separately from anonymised questionnaires and transcripts to prevent participant identification.

2.6.4. Consideration of potential distress

The possibility that participants may become upset if sharing difficult experiences was considered and referred to in the participant information sheet, along with ways that support could be offered following interview (see Appendix E). Interviews were constructed so that participants felt as safe as possible to speak about their experiences, and prior to the commencement of interview, a discussion took place about how best to manage distress should this arise (e.g. offering breaks). At the end of interview, each participant was debriefed and given the opportunity to discuss any issues that arose and ask any questions. If further support was indicated, then this was fed back to the CMHT with consent. One of the participants became distressed during the interview but wanted to continue after a short break. I regularly checked that she was happy to continue for the duration of the interview. She gave permission for me to feed this back to her care coordinator.

2.7. Procedure

2.7.1. Materials

2.7.1.1. Digital audio recorder

All interviews were recorded using a digital audio recorder.

2.7.1.2. Interview schedule

The interview schedule (Appendix H) was constructed prior to recruitment and was developed over time through consultation with my field supervisor. The questions aimed to explore participant's potential identification with, and experiences of maladaptive schema modes outlined by Young, Klosko & Weishaar (2003).

Descriptions of Young's modes were simplified, printed onto card and presented to participants (see appendix I). Consideration was given to the language used on the mode cards to make descriptions accessible to participants and enable them decide whether the mode was relevant to them or not. Questions relating to modes were asked in a flexible and exploratory way and participants were encouraged to expand on pertinent points when relevant. If a participant stated that a mode was not relevant, this would be acknowledged and the next mode was presented. If they said they had experienced a mode, further information was sought with regards to potential triggers, thought processes, feelings, and actions taken. These follow-up questions were based around the theory that modes are "moment-to-moment emotional states and coping responses" (Young, Klosko & Weishaar, 2003; p.37).

Attention was also paid to the order of which modes were presented to participants. Mode cards thought to induce uncomfortable emotional states were identified (e.g. *vulnerable child* mode) and were presented between those that were more neutral. These were identified based on case study reports (e.g. Bamber, 2004) and through discussion with my field supervisor, a chartered psychologist who has experience practicing and researching ST.

Interview items were also reviewed and evaluated by my field supervisor to ensure questions and mode descriptions were appropriate. A pilot interview was subsequently conducted with a colleague to assess the language used and determine an approximate time frame for how long the interviews should last.

2.7.2. Data collection

Semi-structured interviews were conducted at participant's CMHTs, and lasted between 50 and 90 minutes. Prior to interview, participants were given the information sheet to re-read, were asked to sign the consent form, and were asked for some basic demographic information. Participants were then asked to describe their experiences of extreme mood states in their own words, in order to identify whether they had experienced both mania and depression. Clarification was then sought on how they described their mood state relative to these experiences at the time of the interview.

Participants were briefly introduced to the mode concept. They were then presented with mode cards (Appendix I) and the interview schedule was used as a guide to ask participants about their possible experience of each mode in their current mood state. Following an exploration of the experience of each schema mode, participants were asked if they identified with any of the modes in other mood states (e.g. depressed, manic) and whether they perceived there to be any relationship between particular modes and mood states. At the end of the process, they were given the opportunity to reflect on the process, ask any questions and debrief. They were also asked if there were any parts of the interview that they did not want transcribed.

2.8. Data Analysis

Analysis of the data occurred in three stages: transcription of the data, organisation of data into eight matrices (one per mode), and TA of data corresponding to each mode. Braun and Clarke's (2006) paper was used to guide the TA process following familiarisation with the data and it being organised into matrices.

2.8.1. Transcription of interview data

Interviews were transcribed close in time to the audio recording of the interview to enhance accuracy. This aided familiarisation with the data (Braun & Clarke, 2013). Recordings of all interviews were transcribed at a semantic level, placing emphasis on the actual words said and grosser linguistic components (e.g. laughter, pauses). Transcription conventions used for this study were based on Braun and Clarke's (2013) notation system (see appendix J). Any identifiable information was removed or substituted with an equivalent replacement word. Once transcripts were

completed, audio files were listened to again and compared to the transcripts to check for any errors.

2.8.2. Construction of matrices

At the second stage of analysis, data was organised according to schema mode. Miles and Huberman (1994) recommend the use of a matrix table to organise large quantities of complex data ready for analysis. Eight matrices (one for each mode) were constructed in accordance with their recommendations. Each mode matrix had column headings that were based on the theoretical premise of how modes operate. The theory driven column headings included: 'contributing factors', 'experience of mode', 'responses to mode' and 'relationship between mode and mood state'. Each participant's data was allocated to a row.

2.8.2.1. Coding

Prior to initial coding, all transcripts were read through to familiarise myself with the data. Each transcript was then read again, systematically coding extracts of data that appeared related to any of the eight modes. Extracts of data that seemed relevant to the mode that participants were currently being asked about were highlighted in green and coded in the left-hand margin. The right hand margin was used for coding examples of modes arising in interview that the participant was not directly being asked about (i.e. when they were being asked about another mode) and the text was changed to blue (see appendix K for a sample of annotated transcript). This was in order to ascertain whether participant's experiences appeared consistent with any of the mode descriptions, regardless of which they were being asked about, and to see how much of the data appearing to reflect schema modes arose when participants were directly asked about them. At the end of this process, data was organised into the eight matrices.

In order to ensure accurate coding into mode categories, a more detailed definition of each mode was used (see appendix L). Attempts were made to increase the reliability of coding by computing coefficients of agreement between myself and the TCP conducting a similar study. 16 coded extracts were reviewed by my colleague and following this process, we discussed any areas of disagreement. There was initial disagreement on four of the sixteen extracts. At the end of the process, there was disagreement on two extracts. Cohen's Kappa was calculated as 0.77 (see

Appendix M for calculations). A Kappa of $>.70$ is generally considered satisfactory (Cohen, 1960).

2.8.3. Elucidating themes

This phase of analysis involved looking for similarity between codes both within a matrix and across participants, and creating broader codes and themes.

Consideration was given to relationships between codes and sub-themes and how they might combine and connect to form overarching themes (see appendix N for example of themes developed for the *punitive parent* mode).

2.8.4. Reviewing themes

Themes were checked to ensure that they cohered in a meaningful way, and that they fit across coded extracts, matrices and the full transcripts. This process involved two phases:

- *Level one*: Collated extracts for each theme were read to consider whether they appeared to form a coherent and distinct pattern. Themes that only had small amounts of data attached to them were collapsed into broader themes. At this stage, a thematic map was created (Braun & Clarke, 2006; see figure 1.)
- *Level two*: The validity of individual themes was considered in relation to the whole data set by reviewing each transcript and re-checking the matrices for each mode. This enabled any data missed in earlier coding stages to be identified and coded and ensured that the thematic map coherently reflected the meanings evident in the data set as a whole

2.8.5. Defining and naming themes

Consideration was given to the story conveyed by each theme and how it related to its respective mode and the data as a whole. Names were given to each theme.

2.9. Evaluating the Quality of the Study

I drew on Yardley's (2000) four criteria as a framework for formally ensuring the quality and validity of this study:

- Sensitivity to context

- Commitment and rigour
- Transparency and coherence
- Impact and importance

Adherence to these principles will be reflected upon in detail in chapter four.

3. RESULTS

This chapter presents the overarching themes and sub-themes identified for each mode and concludes with a summary of the findings.

Due to the short length of the research interviews and lack of follow-up, participants were not directly asked about their childhood experiences to prevent causing undue distress. Therefore, it was not possible to determine whether particular thoughts, feelings and behaviours described by participants were responses to unmet core needs (reflective of the child modes) or indicative of an internalised parent (reflective of the parent modes). The implications of this are considered in chapter four.

Although brief interjections, connecting words and repetitions of words were transcribed, these have been removed from this chapter as they were not interpreted for the purposes of analysis. Words removed from quotes to reduce length are indicated by '...' Text added to assist clarification of quotes is indicated by square brackets [text]. All extracts are accompanied by participant's pseudonym. The abbreviation 'Int' has been used to refer to myself as the interviewer.

3.1. Summary of Themes

A thematic map displaying each of the modes with their underlying subordinate themes can be found in *figure 1*. Whilst interview questions were theory-led, I also endeavoured to remain close to the data during analysis. Therefore, the variation of themes for each mode reflects participant's responses and reported experiences.

There was insufficient data to be able to draw themes or meaningfully report on two of the modes (*impulsive child* and *overcompensator* modes). These modes are considered further in chapter four. The remaining six modes (see figure 1.) are examined in turn, and themes are illustrated by excerpts from transcripts. A discussion considering the interpretation of findings in relation to the research questions and existing literature is provided in the following chapter.



Figure 1. Thematic map of six schema modes

3.2. Demanding (Parent) Mode

This mode relates to having high standards for oneself and pushing oneself to achieve. Sharon, Zehra, Eymen, Lucy and Amy all shared holding attitudes that related to this mode and described how these could influence their behaviour. Participants suggested that mood state influenced the degree to which these attitudes were acted upon. Three themes were identified: 'Demanding attitudes' 'battling with demandingness' and 'perceived influence of mania'.

3.2.1. Theme one: The self as demanding

Demanding attitudes were held by all of the five participant's. Some held beliefs about themselves as "perfectionist" (Zehra/98) and this was associated with wanting things to be done well or to have them "looking a certain way" (Eymen/114-115). The majority of these participants considered these standards to be internal to them. For example, Lucy commented: "It's like I've got this thing in me, that I could just push myself to an extreme" (244-245). Eymen also suggested that such standards were internally driven:

I do try to do things meticulously well and its not because of any pressure to achieve, its just because I can be a bit pedantic. (Eymen/102-104)

For some participants, it seemed that being demanding of oneself was an attempt to avoid the unpleasant emotions associated with not achieving according to set standards. Eymen described how not finishing a task to high standards would lead him to feel like "a quitter" (111). Lucy also described how she had pushed herself to extremes with exercise to avoid feeling badly about herself:

I push myself to the extreme where I will hurt myself and I wouldn't feel... Say if I only stayed for an hour, I would feel bad about myself. I wouldn't feel that I achieved anything. (Lucy/239-241)

Amy described putting pressure on herself to get her coursework done quickly, despite acknowledgment that since her brain injury, she often needed to work at a slower pace. For her, the anticipation of not meeting standards appeared to be linked to self-criticism:

And I'm just 'argh', you know, just like 'why don't I just get on with it? Work a bit faster.' And I just start thinking 'I'm just always going to be a bum'.
(Amy/315-317)

During her interview, Amy described how she was brought up in a family of high achievers and how she felt that her experiences of struggling to complete a course were assumed by her family to reflect her inadequacy: "But my family, they just assumed that it was because I wasn't good enough (261-262). Amy's experiences of putting pressure on herself to achieve might then reflect development of an 'internalised parent', as described by Young, Klosko and Weishaar (2003).

3.2.2. Theme two: Battling with demandingness

Statements related to the experience of demanding attitudes seemed to imply that these could take over to the point that they were uncontrollable. The analogy of "a dog with a bone" (Sharon/163) was used by Sharon when referring to how she completed tasks, whilst Eymen described almost a compulsion to meet his "meticulous" standards despite implying that this felt overwhelming:

Its ummm, it's like being snowed under and you know that you're under but you have to keep digging to get out. (Eymen/126-128)

Some participants described how such standards had a negative or sometimes catastrophic impact on their relationships, physical health or occupational functioning. Recognising this, participants had described trying to reduce them:

Sometimes I don't like the way I talk to them [family]. I wish I didn't do that. I know that it's not going to help, being perfectionist, and I'm trying not to do. I'm trying my best. (Zehra/193-195)

However, it appeared that demanding attitudes were difficult to control. Lucy described how she had become "obsessed" with exercise and her weight and had reached the point of avoiding things that she used to enjoy to prevent demandingness from taking over:

Yeah. I don't wanna be obsessed with anything again cos it's, it's, it gets too much. And you're never satisfied with anything and it just goes on and on. Yeah, I used to be really into sport believe it or not. But now I've sort of gone the other way I think, because I don't want to get back there. (Lucy/275-279)

3.2.3. Theme three: Perceived relationship with mania

All five participants talked about how pushing themselves to achieve goals or standards was to experiences of mania in some way. Zehra described how she gradually became manic whilst feeling under “stress” and “pressure” not to “make mistakes” during her university course (607-619). Lucy also described how she became increasingly unwell as she put uncontrollable pressure on herself to do well at her course:

So I was going to bed, you know, learning. I couldn't stop it [revising]. It was on and on, it was constant. And I was so [...] I put myself in such a state, I ended up becoming unwell. Because I really wanted to pass well. (Lucy/290-293)

It was unclear from accounts whether being demanding of oneself was a cause or response to elevated mood. However, most participants appeared to focus how changes to their internal state played a causal role. For example, Lucy stated that being demanding of oneself was more likely to happen when “getting manic” (215-217), whilst Eymen suggested that these attitudes were more prevalent when “not completely manic but on the manic side. Elevated” (477). Sharon more explicitly said:

I think that my [manic] mood state influences the mode. By making me more tenacious and obsessive. Really focused at this point to try to get the job done and, yeah, to achieve. Because I really am putting myself under pressure. (Sharon/788-790)

In summary, five participants spoke about putting pressure on themselves to reach an imposed standard and there was a sense this was difficult to control. Participants' accounts implied that a feedback loop might occur whereby mania and demandingness fuel one another.

3.3. Punitive (Parent) Mode

This mode relates to disliking or thinking badly of oneself, or feeling that oneself deserves punishment or blame. These thoughts might be acted on through being punishing, blaming or abusive towards the self. Sharon, Zehra, Eymen, Lucy and

Amy also identified with this mode. For these participants, being punitive of the self was described as being related to low mood. Three themes were identified: 'Blame over past regrets', 'self-attack' and 'perceived relationship to low mood'.

3.3.1. Theme one: Blame over past regrets

Four of the five participants who identified with this mode spoke about how for them, this related to criticising themselves for past mistakes and decisions. Across participants, this appeared to have a ruminative quality, which was accompanied by intense negative feelings about the self. For example, Eymen spoke about analysing himself in "despair" and feeling that he had "wasted" his life (26-28), whilst Zehra described feelings of self-hatred:

[Being punitive] It's all about the things that I have done in the past. I regret them and I'm wishing not to have done them. And at that moment, I hate myself basically. (Zehra/12-14)

Some participants also spoke about ruminating over how they had treated others in the past. This rumination in itself had a quality of being self-punishing and was linked to the activation of strong and unpleasant emotions, perhaps reflecting an overwhelming sense of the self as 'bad'. Sharon described how this was linked to feelings of "guilt" and dislike for herself (14-16). Amy became tearful as she described feeling that the more difficult and unbearable events in her life were a punishment for the past mistreatment of her sister and that she "deserved all the hardships" (131):

Because I was so cruel to my sister growing up. I think I said to her one time 'that's why I think I've had the life I've had'. (Amy/229-231)

As well as feeling guilty or disliking themselves for past mistakes, the majority of these participants also seemed to engage in thinking about how life might be better if they had made different decisions. Zehra said that this often happened "if something bad happens around me that is nothing nice" (47-57). In one case, this was described as having an 'obsessional' quality, perhaps inadvertently perpetuating self-punishment through awareness that the past cannot be changed:

Oh, just obsessing over things that you can't change and maybe desperately trying to to imagine what your life might have been like if you had made the right choices. (Sharon/75-78)

3.3.2. Theme two: Self-attack

This theme represents self-attack through self-critical thinking and self-punishing behaviour. Self-critical thinking was described by four participants, though the content of thoughts varied. Most commonly, and for all four of the participants, self-criticism appeared to be related to the need to achieve and participant's perceptions that they were not intelligent enough, or didn't deserve to achieve. Participants appeared denigrating of themselves, for example stating: "I must be stupid" (Sharon/22), or "there must be something wrong with me" (Amy/378-381) in relation to this. Lucy described feeling that she might never be able to achieve her goals:

I just feel, that I'm stupid, I'm no good you know, or I'm never going to do anything with my life. I'm never going to achieve anything. Yeah, it's just horrible. (Lucy/301-305)

It was also apparent that feeling that one had not achieved according to society's standards was an added source of distress for some participants and led to self-attacking thoughts. Amy frequently referred to feeling like "a bum and a drain on society" (12). Eymen described the following:

I Just feel, you know, if you know how it feels to feel worthless? I don't feel like I've achieved much in my life ... I've got lovely kids and a great family. But you're not weighed by those things in this society. Your worth isn't measured by those things. (Eymen/335-339)

When discussing this mode, four participants made reference to ways of thinking or behaving that might perpetuate self-attacking. Both Amy and Eymen described how behaviours that they engaged in, potentially to avoid criticism from themselves or others, ultimately backfired. For example, Eymen spoke about "always either showing someone up or showing off" (17-21) during his efforts to succeed at things in life and how this had negative repercussions. Amy described the impact of opposing educators who had made attempts to help her when she was struggling with her course:

I feel like I self-sabotage a lot. I cut my nose off to spite my face and then I have recriminations and just feel even shitter about myself. So it's a never ending cycle. (Amy/366-368)

In these accounts, it was apparent that criticising or blaming others might be used as one way of attempting to reduce negative feelings about oneself. When attack was self-focused, two participants described the process of thoughts becoming increasingly consuming. Although not explicitly mentioned, both Sharon and Lucy seemed to describe a perpetuating cycle of lowering mood and self-attack. Sharon powerfully described how self criticising reached a point of “just focusing on the misery”, akin to “like scratching a scab” (72-75). Lucy described the following:

It [self-criticism] just goes into spirals. It just goes worse and worse and worse and worse. And its like I'm in hell. Just laying there in hell. It's awful. (Lucy/88-90)

3.3.3. Theme three: Perceived relationship with low mood

Four of the five participants who identified with this mode described being punitive of oneself as a key feature of feeling ‘low’. In each account, participants appeared to imply that low mood played a causal role in thinking badly about oneself. For example:

Well at the moment, I think because I'm a bit low, it's just despairing with myself (Eymen/24-25)

Sharon also described how she felt that her period of depression prior to becoming manic “might act as a trigger” (922-924) for thinking badly of herself when directly asked about any potential relationship between mood states and this mode. However, elsewhere in her interview she described how ruminating on past regrets could also become “quite depressing”:

That kind of follows on to other, you know, everything else and not following my ambitions or not following through with love affairs and that kind of thing. And feeling a lot of regret basically. And then that becomes quite depressing. (Sharon/48-51)

Whilst participants all appeared to explicitly describe a relationship whereby low mood was a causal factor for being punitive, some accounts were suggestive of a more complex interplay between mood and this mode.

In summary, the majority of participants identified with this mode, though frequently this was related to feeling badly about the past and ruminating on past regrets and failure to achieve. The majority of participants described thinking more critically of themselves when in a lower mood state.

3.4. Vulnerable (Child) Mode

This mode relates to feeling completely alone, frightened, helpless and abandoned by others. All participants identified with aspects of this mode or described related feelings and experiences. Two themes were identified: 'Self as separate to others' and 'compelled to act in response to feelings'.

3.4.1. Theme one: Self as separate to others

This theme encapsulates participant's reported experiences of often feeling alone or separate to others. There was a sense that participants found it difficult to rely on or trust others, and had felt let down by others in the past. The theme is represented and explored within three sub-themes: 'Feeling alone', 'the dangerousness of depending on others' and 'self as separate exacerbated when manic'.

3.4.1.1. Feeling alone

Feeling alone was an experience described in varying ways by a number of participants. For Eymen, there was a sense of feeling physically alone:

I do feel alone. Like I have no friends. I say that I'm going to go out. But the truth is, I've got nowhere to go and no one to see. (Eymen/153-155)

However, Zehra, Lucy and Eymen all described how despite knowing that they were loved by family members, this did not prevent feelings of loneliness:

I can always entertain that feeling of feeling alone. But I feel lonely in myself. Even if I've got everyone who I love and adore with me, I still feel lonely sometimes. (Lucy/407-409)

This sense of loneliness seemed to be compounded by 'Bipolar Disorder'. Despite knowing that others were around, participants implied that they perhaps felt alone in their despair. Lucy described how despairing itself was a lonely feeling "cos no one can [...] you can't come in and shake my brain out." (417-418). Eymen seemed to describe how even those closest to him could be difficult to talk to, perhaps suggesting that others could find it difficult to separate him as a person from the illness:

The only people I have are at home and even then, I feel like I can't really talk to them because I'll just worry them. They'll think there's something wrong.
(Eymen/155-157)

In describing experiences of being abandoned by others, both Amy and Lucy questioned whether they were in some way responsible for this, perhaps suggesting that they felt socially inadequate or flawed. Amy described ruminating on all the times that she had been "dumped" by others and taking this out on herself (38-43). Lucy questioned the possibility that she had pushed others away:

I'm upset that, you know, people just, everyone's just gone. But maybe I've pushed them away. I don't know. (Lucy/716-721)

3.4.1.2. The dangerousness of depending on others

This subtheme reflects participant's experiences of feeling rejected or misunderstood by people and the ways in which it was implied to be difficult or sometimes dangerous to depend on others.

Four participants described how they had felt abandoned by others. A common thread was feeling that others had abandoned them because of their illness. Amy described "so called friends dumping me because of Bipolar and stuff" (470-472), whilst others described abandonment more specifically during episodes of mania or depression:

... when I was ill, when I was in depression... They all went away and didn't ask for a couple of years. They didn't come and call or nothing (Zehra/417-420)

Zehra described how she still thought about this time and it made her feel alone and uncared for. Amy became emotional when recalling a recent experience of feeling misunderstood and unheard by her family:

And I try to explain to him [grandfather] that I'm unwell and he's just like 'you always say that' [shouting]... So I try to explain it to them that I'm a bit vulnerable and its like 'it's all about you!' [shouting] and I get upset and things like that [sobbing]. (Amy/505-511)

Participants felt that their illness had made them more vulnerable to being taken advantage of or hurt by others, perhaps suggesting that they had been victims of stigma and discrimination for many years. In her interview, Lucy described how when she was diagnosed, "mental illness was like a taboo" (192). As well as implying what Lucy believes others might think about her, the following statement might also reflect a sense of shame and internalised stigma:

There still nice to me, you know, they still treat me like I'm normal cos, you know, I don't walk about like I'm nuts and I can have a normal conversation. But I can see [.] I know that you know I've got Bipolar. (Lucy/182-185)

In some cases, such experiences had led to detachment from others over time. Michael's statement suggested that he felt his illness made him undesirable to others and that he expected rejection:

And do they want to be around someone that may be vulnerable at any given time? So to find people, or find a person to be around is ummm, its difficult. (Michael/327-329)

In some accounts, it was clear that there was a felt danger in relying on others who, for example, might "see it as an opportunity to take something" (Michael/350-350). This was also described by Amy:

Some people are really nasty and they pretend they're really nice. And then they show their true colours. Those are the ones to be aware of. (Amy/122-124)

Amy shared thinking that she attached herself "too much" to people, explaining that she did so because of her early life experiences ("because my Mum left when I was

a child” (52-57)). She described feeling that this was one of her “vulnerabilities” as it had resulted in her staying in unhappy relationships in the past. Lucy spoke about feeling too emotionally reliant on her family. For her, the dangerous quality of these relationships was the constant fear that she would imminently lose them:

It's terrible fears of [...] mostly death, you know, like 'oh, I'm going to lose my family, what am I going to do' (Lucy/376-377)

3.4.1.3. 'Self as separate' intensified when manic

Five participants described feeling more intensely alone or separate to others during mania. This appeared related to drastic changes to their sense of self during mania, which meant that they felt it was difficult for others to connect with them. For example, Sharon described feeling as if nobody is on her wavelength whilst manic, which she said led to feeling “very isolated in my own world” (831-832). Basima described how feeling “completely different” when manic led to thinking she was being “pushed away” by others (49-51).

Despite wanting to be around others, Basima described feeling as if people took advantage of her when she was at her most vulnerable:

... you just need protection [when manic]. Because you're vulnerable, you're extra vulnerable, there's chance of you being taken advantage of as well. You feel like you can't express your emotions, so they just take advantage of that (Basima/747-749)

Zehra and Lucy implied that feeling alone, even if others were around, was a considerable cause of anxiety when manic. Zehra spoke about how she believed when manic that there were some “bad people out do do bad things” and how she felt alone and anxious during this experience:

“That's why I was mainly anxious. There wasn't any people around me. I was by myself. I was thinking like that” (Zehra/633-636).

Lucy's comment communicates a sense of feeling hopeless and alone during mania:

Some nights I don't sleep at all [when manic] and I get so anxious and on edge all the time. I feel that no one can help me and I'm stuck with this brain. You know. It's there. I can't get it out. (Lucy/884-891)

3.4.2. Theme two: Compelled to act in response to feelings

For four of the participants that described feeling lonely or rejected by others, there was a theme of wanting to take action in response, perhaps in an attempt to gain control of difficult feelings. For Lucy, this came in the subtle form of considering retaliation in response to feeling “vulnerable” and emotional “pain” when ignored (480-483), whereas Amy and Basima suggested that they engaged in more reactive forms of retaliation by becoming angry and rejecting others. For example, Basima described her reaction to her boyfriend not agreeing to take her to dinner:

Basima: I said ‘Fine. Don’t take me out. I’ll take myself out’.

Int: OK. And what were you feeling in that moment?

Basima: I felt a bit, sort of, in that moment I felt good about myself.

Int: What was making you feel good about yourself then?

Basima: I think it’s the fact that I have the ‘I don’t care’ attitude... I’ll do whatever makes me happy and I don’t need you to make me happy.

Int: So what was the emotion?

Basima: The emotion was anger, rejection and anxiety. (Basima/326-332)

Two participants also described what seemed like quite an overpowering or uncontrollable need to connect with others in response to feeling alone or rejected. For example, Zehra described how she regrettably pleaded with her daughter to come home as she was feeling lonely and said: “I couldn’t stop myself” (333). Amy spoke of reactively leaving the house in the middle of the night after her boyfriend didn’t call:

Amy: I then got dressed... and I [went out and] made friends with this guy in a hotel. He does graveyard shifts, so I just go and chat to him for a while. But it’s still putting myself in harms way.

Int: Yeah. And what do you think it was that made you want to do that at that moment?

Amy: Because I wanted to connect with someone (Amy/711-719)

In summary, most participants experienced feeling lonely or rejected by others and this appeared compounded by having a mental health diagnosis. Some participants

appeared to respond impulsively to feelings of abandonment by rejecting others or seeking connection. Feeling separate to others was intensified during mania.

3.5. Angry (Child) Mode

This mode relates to feeling anger and rage, finding anger difficult to control, or having violent thoughts and impulses. Examples of anger were given by all participants. However, three participants in particular described regular experiences of anger, with responses that appeared disproportionate to their situation. Three themes were identified: 'Anger and conflict with others', 'anger not experienced in isolation' and 'anger in mania'.

3.5.1. Theme one: Anger and conflict with others

This theme encapsulates participant's experiences of anger, many of which resulted in conflict with others and appeared to have an impact on relationships. This theme is represented and explored within three sub themes: 'Anger caused by mistreatment from others', 'they think I'm being aggressive – I'm not' and 'controllability of responses to anger'.

3.5.1.1. Anger caused by mistreatment from others

Three of seven participants spoke about experiences of anger throughout the interview, perhaps suggesting that this was more present in their everyday lives. A shared experience across each of the participants was the sense that anger occurred in response to feeling misunderstood or disrespected by others. For example, Basima described becoming angry when she felt that others were being judgemental of her, and Amy described anger being triggered by interactions with her family:

*My sister tries to say that I depress everyone. And that makes me fucking angry because I get the blame even for my depression...
So it's their ignorance. (Amy/664-667)*

Sharon described how getting angry and shouting could "cause problems" (285 286) for her, particularly at work. This was mostly triggered by feeling undermined by others:

Yeah, that kind of injustice. That I'm being used to further someone else's promotional ambitions ... And so that makes me really angry. (Sharon/339-344)

In her interview, Sharon described how at work she felt frustrated with being “expected not to answer back” (351-355) because of her lack of seniority and felt at “liberty” to speak her mind. For Sharon, it is possible that expressions of anger might be a defence against unbearable feelings of powerlessness or humiliation.

The justification of anger towards others was apparent across all three participants and there was a sense that this felt like a necessary response to Being overpowered or undermined. For example, in her interview, Amy denied feeling that anger was a problem for her but said: “No. Well, I get angry and I scare people with my anger but I don’t touch anyone. They do it to me” (586-587). Basima provided her justification for “punishing” her husband for not topping up the gas:

He wasn't listening to me. That's what made me change my behaviour. If he had of listened to me then I probably wouldn't have done what I did. (Basima/216-218)

3.5.1.2. *They think I'm being aggressive – I'm not*

On recalling past or recent expressions of anger, five participants implied that they felt others responses to their anger had been a threat to the way that they perceived themselves. For example, Michael described how being told he was “verbally aggressive” was at odds with the view he had of himself, and how he had to “consult with one or two colleagues about what the verbally aggressive one meant” (661-668). This was similarly described by Eymen:

And I've had, you know people in the council or the housing office telling me that I'm being aggressive. And I just get confused you know? Because I've just maybe, spoken a bit loudly, and they think I'm being aggressive. I'm really, not aggressive. (Eymen/237-241)

The experiences described by participants might reflect anger as unconscious, or perhaps the difficulty taking into account the perspective of another when feeling under threat and experiencing intense emotion. Basima described how others intervening to diffuse the situation led to a gradual realisation that her behaviour had impacted negatively on another person:

She [Mum] was like 'what did you do that for?' and then she's like 'I don't really want to speak to you anymore'. So I just kind of come to the realisation that I didn't probably do the right thing. (Basima/221-224)

3.5.1.3. Controllability of responses to anger

The majority of participants spoke either directly or indirectly about the controllability of anger. Sharon, Eymen and Amy all described efforts to suppress anger. Eymen described feeling unable to express anger as this was for him, associated with being a violent person: "You just get so angry that everything is boiling up but you just, you can't even express it" (229-232). For Sharon, suppression of anger resulted in "a build up of kind of frustration and then I'll just lose it" (379-380). However, for her, anger could be consciously controlled and dependent on context:

... I mean, I could control it. The thing is, I've been in lots of corporate jobs where I have controlled it and I would usually walk away, go out for cigarettes and go to the toilet; take deep breaths and just bottle it you know? But maybe because it's in the public sector and I've got a permanent job..., I feel more at liberty to speak my mind [laughs]. (Sharon/368-373)

There were other occasions where participants had experienced anger that was more reactive. Amy spoke described how being "impulsive" meant that she could act on anger and regret it later ("sometimes I don't pick my battles well" (899-901)). Eymen spoke about a recent incident of uncontrolled anger with his son, where physical sensations appeared to take over: "I just felt my whole face get really hot and I just grabbed him and slapped him. Slapped him a few times" (260-261). Basima described how experiences of reactive anger left her feeling badly afterwards, perhaps suggesting that such interpersonal experiences could later contribute to self-attack:

The feelings [of anger] all went away and it was replaced with guilt ... It happened quite slowly. Afterwards it kicked into me, the realisation. And then I thought 'what did I do?' (Basimia/210-213)

3.5.2. Theme two: Anger not experienced in isolation

Evident throughout the accounts of anger was the theme that anger was not experienced in isolation. Emotional reactions to situations were complex and multifaceted. Eymen, Sharon, Basima and Amy all spoke about how more reactive forms of anger were preceded or accompanied by other emotions including disappointment, worry and sadness, anxiety or feeling vulnerable respectively. Basima described how “the feeling of hate came” in response to initially feeling ignored and neglected (700-702). Similarly, Amy spoke in interview about how she had felt angry when she sent her boyfriend an email “dumping” him when he had not called. However, this appeared in response to feeling abandoned and rejected:

I cemented the fact I can't be doing with this. You've got to be a man of your word or just don't say it [raising voice]. Because he knows I'm feeling vulnerable right now (Amy/636-638)

It is possible that for these participants, experiences of anger hold several functions, such as converting feelings of helplessness and vulnerability into feelings of control and power. Sharon described her emotional response to her friends excessive drinking: “... that really kind of worried me, upset me. But then I thought 'well I'm also quite angry about it'” (384-386). For her, anger might hold the function of protecting her from more painful emotions. She goes on to describe this later in her interview:

Because you know, maybe I'm not very good at dealing with depression and feeling sorry for myself and I'm more likely to get angry about things than feel the grief or the sadness or, you know. (Sharon/867-871)

3.5.3. Theme three: Anger intensified in mania

Five participants spoke explicitly about acting on feelings anger when in hypomania and mania. From most of the accounts, it was apparent that anger remained in response to feeling threatened or under attack from others, but that anger felt harder to control. Michael said that when manic, “its that things get hypersensitive” (643-

645). This was described well by Sharon, who spoke about the impact of changes to the body and mind:

When I'm getting hypomanic, I can quite often be very short tempered and intolerable of people and also I feel like a knot in my stomach a lot of the time ... Then, then I get really short. Its just like being really overtired, you know? (Sharon/844-848)

Lucy and Eymen spoke about experiences of becoming aggressive in hospital as a result of both feeling under threat and unable to rationalise due to an altered state of mind. For example, Eymen spoke about how not being able to see his children whilst in hospital had sent him “into a fury” resulting in him being placed in seclusion. He described feeling “impulsive” and unable to rationalise:

I wasn't able to work out that it [not seeing children] was just a temporary thing and that ultimately the staff were just being unreasonable and unkind and that it would be something that I would be able to resolve with patience. (Eymen/421-424)

In summary, the majority of participants spoke about experiencing anger and reacting to this, most often in response to feeling threatened. This could impact on work and relationships for some participants. Often, anger was not experienced in isolation. In mania, participants described becoming more hypersensitive, sometimes acting on anger in extreme ways.

3.6. Compliant Surrenderer Mode

The compliant surrenderer mode relates to putting other people's needs before ones own, tolerating mistreatment or acting in subservient ways out of fear of conflict or rejection. All participants spoke about having experiences that related to this mode, though overwhelmingly this was something experienced in the past or was a way of relating that participants were actively seeking to change. Two themes were identified: 'Self as submissive' and 'resisting subjugation'.

3.6.1. Theme one: Self as submissive

Acting submissively in interactions with others was an experience reflected in the accounts of six of the participants, although this was done in diverse ways. Commonly, participants reported tolerating verbal abuse, criticism, or being ignored by others. Lucy and Amy suggested they were repeatedly treated badly by the same people. For Amy, this appeared to be associated with self-blame for being too forgiving:

Yeah. Because I've forgiven people who were nasty to me and everything. I've forgiven them too many times and it's like no wonder that I've got crap friends. (Amy/811-813)

Lucy explained that her boyfriend had regularly ignored her for days at a time and said: "But I was so into him that I'd put up with it. And it kept...[happening]" (460-464). She described how being ignored had left her "feeling vulnerable." (471), but that she kept this to herself:

I'm thinking 'I called hours ago, how comes you didn't answer?' But you don't let anyone know what you're actually feeling. No no. (Lucy/487-488)

It is possible that by not feeling able to share her thoughts and feelings, Lucy had become trapped in a continued cycle of being ignored, in turn reinforcing feelings of vulnerability and abandonment.

Three participants talked about not expressing their own thoughts and feelings, which appeared another way of acting subserviently. This may have been in endeavours to avoid arguments or difficult conversations. For example, when criticised by her daughter, Zehra said: "I didn't say anything else to her. I just accepted like that" (551-554). Eymen described putting his own needs and feelings aside to protect his family from worrying:

Well, I have to pretend things are OK when I'm with my family. So that they don't worry. (Eymen/386-387)

3.6.2. Theme two: Resisting subjugation

When discussing this mode, the majority of participants focused on their identification with the mode in the past, and how it had become less relevant over time. All participants appeared to engage in thinking or behaviour that resisted

subjugation and this appeared to have a ruminative quality. This included showing resentment for being compliant in relationships, considering the need to change and actively taking care of one's own needs.

Resentment towards this way of being by some participants could reflect a more subtle act of resistance. Sharon spoke about feeling indebted to her ex-girlfriend: "[she was] instrumental in stopping me going completely off the rails" (513-514) and how she felt this had been used against her:

But she kind of uses that in a way, you know, in a power balance. That she then can call [..], do what she wants and that. ... And I've been in that relationship with her for many years. (Sharon/516-524)

Eymen spoke about how taking on increasing amounts of work for his community group had led him to feel as if he was being taken advantage of and how he would ruminate about this. His description invokes a sense of feeling downtrodden and humiliated by this:

I just felt resentful ... It just felt that they were laughing. Like I was everyone's mule. Carrying the weight of this 'thing', you know? (Eymen/320-321)

Another way participants appeared to resist subjugation was through considering the need to change their behaviour. This seemed to vary in degree. Sharon and Lucy appeared to have resigned to this way of being, yet acknowledged that this was unfair on them, as suggested by Sharon:

Well, part of it is just like 'well, that's just the way things are' ... But then she [ex-girlfriend] has treated me badly as well. (Sharon/528-531)

Other participants felt more of a desperate need for things to change, seemingly growing from the realisation that others weren't caring for, or respecting them. Amy described feeling "ridiculed" by her family. In relation to this she said: "I'm trying to get out of this role that I'm in, where I'm mistreated and subordinated and stuff like that." (853-856). Similarly, Zehra spoke about her expectation that relationships should be equal:

They don't call, they don't come [cousins]. I have to get in touch all the time. First of all I have to do. But I don't want to be first anymore. I want to do that equally (Zehra/450-453)

In relation to this mode, many participants also spoke in various ways about self caring to prevent subjugation. Lucy suggested the need to “have a stop” (651) to prevent people taking advantage, whilst Basima spoke about how having therapy had helped her to assert her needs:

It's really helped, like being able to say no to people and being able to stand up and be assertive in a good way. (Basima/524-526)

The need to care for one's own health was something that three participants raised as having influenced them in ensuring that they put their own needs first. This is illustrated by Eymen's statement, which suggests that he was mindful that working to please others could contribute to changes in his mood state:

Well, I had to just start thinking of my own mental health. You know? And, I wasn't happy as well. It was making me really unhappy. (Eymen/331-332)

In summary, most participants suggested that they had experienced silencing their own thoughts, feelings and needs in relationships. However, overwhelmingly this was something that participants were actively resisting, or had reduced over time.

3.7. Detached Protector Mode

The detached protector mode refers to avoiding experiences that one finds difficult. This might include social contact, painful emotions, or thinking about one's problems. The majority of participants spoke about avoiding painful experiences and most frequently this was described as conscious and deliberate. Two themes were identified: 'Disconnection from thinking and feeling' and 'detached coping as fuelling negative emotions'.

3.7.1. Theme one: Disconnection from thinking and feeling

3.7.1.1. Avoidance of emotion

Three participants described feeling as if they were overly sensitive to becoming distressed and so avoided situations that might trigger difficult emotions (e.g. social contact, thinking about problems, watching the news):

I close myself at home. I am not going out. And, if I distress myself, I start flinching and uh, some body movements happen unwantedly to get away from them [people who trigger negative emotions]. (Zehra/487-491)

Participants all communicated in their statements the potential dangerousness of experiencing negative emotions. For example, Zehra said: “even though I do something [distraction] it doesn’t stop” (498-500). This might imply that once triggered, she felt she had little control over negative thoughts and feelings. Similarly, Sharon avoided thinking about herself and problems, stating: “that can make me depressed and that’s not a state that I want to be in” (611-613).

For a smaller number of participants, there was also a sense of a more aloof detachment from others or from emotion. For example, Sharon spoke about sadness not being an emotion that she dealt with “in a very self indulgent way” (570), whilst Michael said the following in relation to avoiding relationships:

... one of my friends used to say [laughs] that I reminded him of a Greek, mythical immortal that had no feelings and no [laughs]...yeah. It’s the way I’ve presented myself to people. So yeah, somewhere along the line from my personal socialisation development, I found coping strategies, mechanisms, to not really get pain or hurt emotionally ... (Michael/272-279)

3.7.1.2. Self-soothing

All participants spoke about using distraction or self-soothing as coping strategy. Often, this was in response to self-critical thoughts or feelings of loneliness.

Some behaviours appeared to have a deliberate aim of being numbing to enable a complete detachment from unpleasant emotion. Lucy spoke about using alcohol to “numb” herself so that she could “cope” with feelings of inadequacy when with her friends (770), whilst Eymen described hiding from his emotions:

That's my way of hiding at the moment. And it works. Because you go to bed and you shut your eyes and nothing exists anymore. You just dream and usually dreaming is more pleasant than real life you know? (Eymen/350-353)

Some behaviours appeared less extreme and involved distractions such as watching TV or overworking. Two participants spoke about the tendency to overeat in an effort to feel better, as described by Basima:

Sometimes if I feel bored or if I feel lonely I can feel like I need to eat something. And then I just kind of use that emotion to snack on things. (Basima/577-579)

3.7.2. Theme two: Dissatisfaction with detached coping

Although participants engaged in avoidance or distraction, four participants appeared frustrated with this coping strategy. Amy spoke about how using distraction as a way of coping led to her feeling “even more depressed” because she would then criticise herself for being the “worlds worst procrastinator” (148-150). In her interview, Sharon spoke about how a self-compassion book she was reading triggered self-critical thoughts, resulting in her leaving it on the train:

Sharon: And then I regretted it because I did want to read more you know?

Int: And how did you feel in yourself in that moment?

Sharon: I just felt quite angry and annoyed with myself. (Sharon/628-631)

Lucy spoke about how avoidance had led her to feel that she was trapped in a vicious cycle:

I keep making excuses not to go out because it's just so much headache. And then I feel low because I'm thinking, 'well I'm not socialising, I'm not doing anything'. It's like a vicious cycle, how I'm feeling now. (Lucy/43-46)

In each of these accounts, it appeared that participants were demanding themselves to be better in some way, for example more productive or more sociable but were trapped in a cycle of detached coping that was difficult to control. Seemingly, this realisation could result in self-attack.

In summary, a range of strategies were adopted by participants to avoid difficult thoughts and feelings. For four participants, there was an explicit acknowledgement

that this way of coping had negative consequences, perhaps reflecting a desire to change.

4. DISCUSSION

This thesis aimed to preliminarily explore the descriptive value of modes through qualitative methods. This chapter examines the research findings, referring to the two research questions outlined in chapter one and in relation to relevant literature. Methodological limitations are considered and the study is evaluated against standards for good quality research. This is followed by a reflexive account of the research process. Implications of the research are then discussed before providing a concluding summary.

4.1. Discussion of Findings

4.1.1. Research question one: How do participants respond to descriptions of schema modes?

The first research question sought to explore participant's responses to schema mode descriptions. Specifically, the research was interested in whether participants described experiences that were consistent with, or in some ways distinct to Young's modes and how they are theorised to operate.

Although participants appeared generally to relate to many of the mode descriptions presented to them, inductive Thematic Analysis (TA) of the data relating to each of the schema modes highlighted some important aspects of participant's experiences that were subtly distinct. Analysis of the data also revealed relationships between themes across the *punitive* and *demanding parent* modes, and the *vulnerable* and *angry child* modes, which appeared to be reflective of an overlap between modes in participant's accounts. These findings will be discussed in turn in relation to the overall descriptive value of modes. Modes not included in the TA due to insufficient data, are also discussed.

4.1.1.1. Findings relating to the adult modes (punitive and demanding parent)

Themes relating to the *demanding parent* mode suggested that the majority of participants could set themselves high standards, which were difficult to control. For some, reducing one's efforts or standards was avoided as this could result in self-criticism. These findings might be supportive of previous studies, which have found

high levels of perfectionism, self-criticism and goal striving in those with a BD diagnosis (e.g. Lam, Wright & Smith, 2004; Strange et al., 2013).

Whilst participants described experiences that were largely consistent with Young's *demanding parent* mode, the analysis highlighted a dominant and shared aspect of their experience that appeared distinct. The mode description presented to participants implied that the need to push oneself may be unrelenting (i.e. "you don't allow yourself to relax until all the work is done"; see appendix I). However, in describing their experiences, participants more distinctly conveyed a *fearfulness* of their high standards and how uncontrollable these felt. Sometimes, this resulted in complete avoidance of activities that could activate them. This might highlight specific and important emotions associated with this way of relating that are distinct to Young's original *demanding parent* mode description (see appendices I and L). If modes were then to be used in ST with individuals with a diagnosis of BD, exploring *how* one relates to the 'demanding' aspect of themselves (e.g. feeling fearful of it) and the meaning and implications of this, might be important for making sense of an individual's difficulties. Given the association that participants made between the *demanding parent* mode and experiences of mania (see section 4.1.2.1), it is possible that this experience is important, and may be unique to individuals who experience extreme mood state disruptions.

The theme 'self-attack' relating to the *punitive parent* mode, demonstrated that in this sample, self-criticism was overwhelmingly focused around ruminating on missed opportunities, mistakes or lack of achievement and that this was associated with feelings of self-hatred, guilt, or worthlessness. Whilst the experiences participants described were then somewhat consistent with the *punitive parent* mode description, it was noteworthy that such experiences were specific and did not, in most cases, appear to reflect a general and stable feeling of hatred towards oneself.

Self-criticism is associated with shame-proneness, which is thought to occur following a negative internal self-evaluation against a set of standards or goals (Lewis, 1971). Shame is suggested to arise from abusive or neglectful child-parent interactions, resulting in a child developing negative internal self-object relations (Schore, 1991). Gilbert suggests that insecurely attached children become focussed on social-rank and others as a source of threat, fearing that they exist negatively in

the eyes of others (Gilbert, 2005). Although participants in this study were not directly asked about their early life experiences, some participants did spontaneously indicate that they had felt let down or abandoned by early caregivers. This could then suggest that the pressure to strive that participants described (associated with the *demanding parent* mode) may be related to avoiding unwanted feelings of inferiority and self-criticism, associated with being overlooked or rejected (Gilbert, 2005) (associated with the *punitive parent* mode). However, further research would be needed to explore the childhood origins of such experiences.

The same five participants identified both with the *demanding* and *punitive parent* modes, and findings suggested that these ‘modes’ operated concurrently in participant’s experiences. Although punitive and demanding aspects of parent voices are typically separated in the ST literature, Young, Klosko and Weishaar (2003) acknowledge that these modes do occur together (i.e. being demanding and then punitive when one fails). The finding that participant’s associated ruminating on failures and mistakes with the *punitive parent* mode may support previous literature which has noted significant overlap between the *demanding* and *punitive parent* modes (Young, Klosko and Weishaar, 2003; Lobbestael, van Vreeswijk & Arntz, 2007). In ST, this has led to compound terms such as the “Demanding/Critical Parent” (Lobbestael, van Vreeswijk & Arntz, 2007; p. 85) being used when these modes co-occur. When considering the descriptive value of individual schema modes, one might then question this overlap between modes and how this ambiguity might be managed in therapy to capture the service-user’s unique experience (Edwards, 2017).

Attempts were made in interview to determine external triggers for the *demanding* and *punitive parent* modes, as well as their frequency, intensity and duration. This was in order to explore whether there was any consistency between participant’s responses and the way in which modes are theorised to operate. However, it was not possible to identify themes across the data relating to these factors. For at least three participants however, it was evident that feelings of worthlessness could be activated in response to negative self-comparison to cultural or idealised norms in terms of achievement. Therefore, although the lack of childhood data meant that it was not possible to ascertain whether modes have their origins in early life as theorised, this research potentially highlights the harmful impact of elevated

competitiveness in Western societies on experiences of self-criticism and shame (Kasser, 2002) and the more distal operations of power that maintain it (Smail, 2005).

4.1.1.2. Findings relating to the child modes (vulnerable and angry child)

When presented with the *vulnerable child* mode card, all participants shared having regularly had related experiences such as feeling isolated, alone and rejected by others. It was noteworthy that across participant's accounts, associations were made between the thoughts, feelings and behaviours represented by this mode description and their experiences of having a diagnosed mental illness. The theme 'feeling separate to others' represented how a distinct part of participant's experience was feeling misunderstood or rejected by friends, family and community as a result of having experienced extreme mood disruption.

Participant's accounts of 'feeling separate to others' suggested that stigma might play a compounding role in their experiences. Stigma is described as a process of discrimination towards a group with a shared characteristic. Often, this becomes internalised into a sense of difference and shame and rejection from others becomes anticipated (Vass et al., 2015). Previous research has also demonstrated that internalised stigma can result in suspiciousness, feelings of persecution and active social avoidance (Vass et al., 2015). Findings from this study suggested that indeed, participants could see others as a source of threat and felt more vulnerable because of their illness. These findings parallel those of previous qualitative studies which have explored the subjective experiences of difficulties faced following a diagnosis of BD (e.g. Proudfoot et al., 2009; Goldberg, 2012).

Although participants did then describe emotional and behavioural states that were consistent with Young's *vulnerable child* mode description, it was evident that such experiences may, at least partly, be the product of being marginalised and discriminated against in adulthood. This might support previous critiques of ST outlined in section 1.7.1.1, which suggest that in its focus on attachment and object relation theories, ST has neglected the wider systemic factors that can also influence ones developing sense of self (Flanagan, 2014; James, 2001). Whilst modes could then have some value in capturing some of the thoughts, feelings and behaviours experienced by individuals with a diagnosis of BD, important aspects of experience

might be missed if the impact of stigma is not also considered in therapy. The role that stigma could play in EMS development or in the operation of modes, has not been explicitly considered by schema theory to date.

Three participants in particular frequently referred to experiences of anger throughout their interviews and responded with examples when presented with this mode card. However, anger was a notably multifaceted and complex emotional experience. The themes ‘compelled to act in response to feelings’ (*vulnerable child* mode) and ‘anger not experienced in isolation’ (*angry child* mode) demonstrated how, for the three participants who regularly experienced anger (Basima, Sharon and Amy), this often occurred in response to (or concurrent to) feeling abandoned, rejected or belittled by others. Frequently, outbursts of anger appeared impulsive, were arguably disproportionate responses to the situation, and could have a negative impact on work or romantic relationships.

The above findings could suggest that these participants experienced heightened levels of ‘rejection sensitivity’; “the disposition to anxiously expect, readily perceive and intensely react to rejection” (Downey, Mougios, Ayduk, London, & Shoda, 2004, p. 668). This is thought to lead to both cognitive (e.g. blaming self or others) and affective (e.g. feeling hurt or angry) reactions, followed by aggression or withdrawal. This may then result in actual rejection as a self-fulfilling prophecy (Staebler, Helbing, Rosenbach & Renneberg, 2011). It seems reasonable to suggest that such rejection could then result in further feelings of abandonment, internalised stigma and shame, perhaps forming a vicious cycle.

Previous research has implicated the role of early emotional abuse/neglect and insecure attachment in emotion regulation difficulties and rejection sensitivity (e.g. Downey, Khouri, & Feldman, 1997). As mentioned, attachment theory suggests that children develop ‘Internal Working Models’ (IWMs) of others as safe and supportive through secure attachment, which facilitates the development of self-evaluation and self-soothing skills (Baldwin, 2005). Conversely, insecurely attached children can develop problems with emotional regulation and are more likely to focus on the power of others to hurt, control or reject them (Irons & Gilbert, 2005). Young suggests that the angry child mode most often operates in response to the unmet core needs of the *vulnerable child* and that individuals can shift rapidly between

these two states (Young, Klosko & Weishaar, 2003). The intense and impulsive experiences of anger in response to rejection for these participants may then be consistent with what has been described by schema theorists as ‘flipping’ between modes (Bamber, 2004), which is thought to reflect transient and intense dysregulated emotional states (Dadomo et al., 2016).

When presented with the *angry child* mode description, some participants responded by commenting on how others had perceived them to be angry and rageful, but that this was not consistent with their own experience. It is possible that feelings of shame prevented participants from admitting to experiences of anger in interview. However, it may be the case that whilst *behaving* aggressively, participants were genuinely not in-touch with *feelings* of anger. Schema theory suggests that activation of a mode involves equal activation of related behaviours, emotions, and cognitions. However, this assumption has never been empirically tested (Lobbestael, Vreeswijk and Arntz, 2007). Findings from this analysis could then suggest that the experiential aspects of anger (e.g. thoughts, feelings and behaviour) are not activated in synchronicity. The theme ‘controllability of responses to anger’ reflected how participants also reported having experiences both of being able to control feelings of anger and of responding to this more impulsively. This might also suggest that aspects of a mode are activated to different degrees at different times, and that this could potentially depend on many factors. These findings may then suggest a need for further empirical testing of how modes are theorised to operate.

4.1.1.3. Findings relating to the coping modes

Many of the participants described experiences that were consistent with the *compliant surrenderer* mode description, including tolerating being ignored or criticised by others. However, analysis of the data relating to this mode revealed a common and unique theme across the whole sample of both resenting and actively resisting subjugation. For each participant who identified with this mode, the extent to which they had allowed their own needs to be subjugated appeared to vary along a continuum.

Although it was not possible to determine conclusively from participant’s accounts how or when use of this coping mode would change, one possibility is that variation in mood state could be an influencing factor. The way in which participants

responded to the mode card by apparently ruminating on the unfairness of having their needs subjugated, suggested that allowing oneself to be subjugated by others could become a feature of self-attack for participants and contribute to low mood. The manic defense hypothesis of BD infers that grandiosity in mania represents attempts to exert power and control as a defense against feelings of powerlessness and worthlessness (Beck and Rector, 2005). If this is the case, symptoms of mania such as grandiosity might be conceptualised in ST as an attempt to set boundaries around the '*compliant surrender*' aspect of oneself.

Young, Klosko and Weishaar (2003) do refer to the changeability of modes, however, the mechanism by which this occurs has received little theoretical or empirical attention to date. Participant's responses to this mode description might suggest that in order for these constructs to have descriptive value for working with those with a BD diagnosis, there may be a need to better understand the changeability of modes and how this could be related to factors such as extreme mood disruption.

In response to being presented with the detached protector mode card, all participants gave examples of how this mode description fit with their experiences, and described how they commonly used strategies of emotional and behavioural avoidance. There was a sense from their accounts that experiencing negative emotions could be dangerous and as such, participants avoided thinking about their problems or avoided situations and relationships that could trigger them. Participants' accounts were both consistent with the mode card description, as well as with previous research that highlights associations between avoidance coping and low mood (Holahan, Moos, and Bonin, 1999). Findings relating to the detached protector mode are discussed further in section 4.1.1.2.

4.1.1.4. Modes excluded from thematic analysis

There was insufficient data to report on two of the modes (*impulsive/undisciplined child and overcompensator*). In most cases, participants did not feel that these mode descriptions were consistent with their experiences of how they related to self and other, and neither of the co-raters were able to conclusively code aspects of the transcripts as relating to one of these modes. Some of the factors that may have contributed towards this are discussed below.

Firstly, the ‘compelled to act in response to feelings’ theme within the vulnerable child mode reflected how participants could respond to situations impulsively. However, in most cases described, acting impulsively appeared to be a response to feelings of rejection, as opposed to attempting to meet one’s ‘non-core’ desires as specified by Young’s *impulsive child* mode description (see Appendix K for mode descriptions that assisted coding). It was perhaps surprising that so few instances consistent with the *impulsive child* mode were apparent, given that previous research has shown high scores on the *insufficient self-control* EMS in this population (e.g. Hawke, Provencher and Arntz, 2011), which is the core EMS associated with the *impulsive child* mode (Young, Klosko and Weishaar, 2003). Whilst it may be that participants did not relate to the mode card description, it is also possible that they were unable to recall experiences of impulsivity and associated triggers, thoughts or feelings in any detail. This may be particularly relevant, given that impulsivity is more likely to occur in mania (Carver and Johnson, 2009). Additionally, this mode card may have been perceived as having negative or shameful connotations, making participants more reluctant to associate with this mode in interview.

The *overcompensator* mode also presented unique challenges when coding, as participants would need to explicitly demonstrate how, for example, presenting as dominant or haughty might act as a defence against feeling badly about oneself. A few instances described may have been suggestive of an overcompensating mode. For example, both Amy and Eymen described inadvertently self-sabotaging in goal striving situations, either by rejecting help when needed or by “showing people up” (see pages 48 and 49). Whilst this could not be generalised to the whole sample, their accounts suggested that such strategies could be used to ‘save face’ when self-esteem was threatened (Gilbert & Proctor, 2006). It is possible is that this schema mode, consistent with the manic defence hypothesis, did relate to many more participants, but that they were not consciously aware of and able to report on this in a one-off interview. Indeed, accurately identifying modes is a process that usually occurs over several sessions (Young, Klosko & Weishaar, 2003). If it was the case that participants were not consciously aware of such a mode operating, then this would suggest that at least initially, mode descriptions may only have descriptive value for the treating clinician. Given that this research has highlighted distinctions between participant’s experiences, mode descriptions and the theoretical

conceptualisation of schema modes; one might suggest that if using modes for case conceptualisation, clinicians need to be able to use modes flexibly and refrain from applying them individuals in an all-or-nothing sense.

4.1.2. Research question two: How do participants perceive the relationship between schema modes and bipolar mood states?

The second research question sought to explore whether participants perceived there to be any relationship between mood states and particular modes, and what this relationship might be like. Participants identified potential relationships between the *demanding parent*, *angry child*, and *vulnerable child* modes and mania; and the *punitive parent* mode and depression. Additionally, 'disconnection from thoughts and feelings' (a theme within the *detached protector* mode) appeared to be used as a coping strategy to prevent self-attack and low mood. These relationships are mapped out visually in *Figure 3*. and findings are discussed in turn. It should be noted that participants were asked about each mode in their current mood state as well as other extreme mood states. This had limitations in that participants were asked to rely on their recall of moment-to-moment emotional and behavioural states when depressed or manic. Additionally, there was limited time in interview to explore non-current mood states in detail. These factors potentially contributed to the collection of relatively thin data relating to research question two.

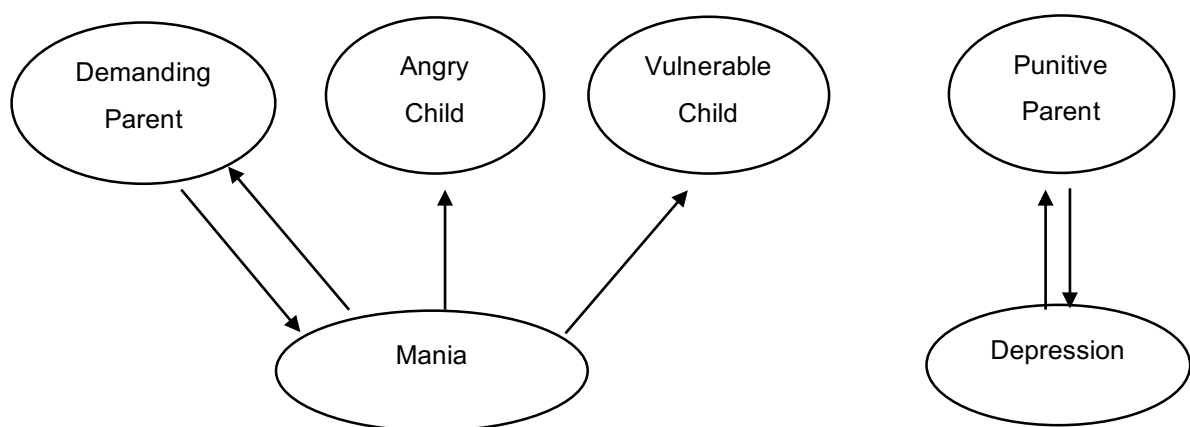


Figure 3. Perceived relationship between modes and mood states

4.1.2.1. *Perceived relationships between modes and mania*

Participants responses in interview suggested that a bi-directional relationship between *demandingness* and mania might exist, whereby one fuels another. As mentioned, it was difficult to ascertain what might initially trigger demanding attitudes, however most participants suggested that elevated mood could play a causal role. This might be supportive of Mansell, Morrison and Tai's (2007) model of mood swings, which suggests that mild changes to internal physiological or emotional state are interpreted as signifying extreme personal meaning (either positive or negative), which then promotes a cognitive and behavioural driven cycle of escalating symptoms (see Mansell, Morrison & Tai, 2007). The data suggests that in this population demanding attitudes could be triggered by a change to internal state as opposed to a situational trigger, as Young more commonly suggests (Young, Klosko & Weishaar, 2003). Although research would be needed to explore this relationship further, the current findings would indicate a need for schema theory to adequately conceptualise how an elevated mood state might play a role in triggering trait-like EMS, which have their origins in childhood.

The finding that participants perceived experiences of anger and 'feeling separate to others' (a theme within the *vulnerable child* mode) to be intensified during mania is perhaps unsurprising. Mansell and Pedley (2008) suggest that the experiences common to those with a diagnosis of BD in remission, such as anger, anxiety or paranoia are more extreme during mania (Mansell & Pedley, 2008). Research suggests that during mania, individuals experience increased activation levels, poor executive control, enhanced processing of both positive and negative personally relevant stimuli and impulsive responding (Cassidy et al., 1998; Clarke & Sahakian, 2006; Lyon, Startup & Bentall, 1999, Murphy et al., 1999). Problems with mentalisation (the ability to relate to others emotional and behavioural states) has been identified as a key mechanism for developing paranoia and has also been found to be more impaired during mania (Lahera et al., 2015). Such experiences may then contribute to feeling intensely criticised or victimised by others (Kerr et al., 2003). Each of these factors might then impinge on one's capacity to regulate emotions and to employ coping strategies (Mansell & Lam, 2006). Therefore, it is possible that if the *angry* and *vulnerable child* modes were intensified during mania, experiences of 'flipping' between these modes, (see section 4.1.1.2.) would also be

intensified. Participants described how anger had resulted in negative responses from others and some described experiences of guilt as a result. One might hypothesise then that such social interactions could serve to further isolate individuals following periods of extreme mood disruption.

4.1.2.2. *Perceived relationships between specific modes and depression*

Participants perceived *self-attack* (a theme from the *punitive parent* mode) to be a key feature of low mood states. Previous studies have found high levels of self-criticism/shame (discussed above) and depression to be correlated (Cheung, Gilbert, & Irons, 2004). Again, it was not possible to identify initial triggers for self-attack. However, most participants implied that low mood could play a causal role. Indeed, previous research has found that dips in mood can trigger self-criticism in those with previous experiences of depression, resulting in a vicious cycle of self-criticism and lowering mood (Teasdale & Cox, 2001).

All participants primarily described cognitive and behavioural avoidance (associated with the *detached protector* mode) as a way of attempting to prevent feelings of loneliness, low mood, or self-critical thoughts, which felt overwhelming and uncontrollable. Once triggered, some participants spoke about how they could get caught up in negative thinking, which has been associated with prolonged negative affect (Nolen-Hoeksema, 1998, 2000). Schema theorists have recently suggested that rumination, the process of repeatedly focusing on the causes, meaning and consequences of one's distress (Papaeogiou & Wells, 2004), may represent a transdiagnostic coping mode (termed the *over analysing* coping mode). It is theorised that this serves to distance individuals from distressing emotional states by inhibiting the emotional processing of present experiences. Over-analysing is known to impede problem solving, which may leave concerns unresolved and trigger further repetitive negative thinking (Brockman & Stravopoulos, 2018). It is possible that in this sample of participants, the attempted use of coping strategies (e.g. avoidance) and cognitive processes such as rumination to cope with self-attack, may in-fact have interacted with it to prolong negative affect. Indeed, the theme 'dissatisfaction with detached coping' suggests that participants did perceive a relationship between detached coping, low mood and self-attack. At least half of participants described how avoidance, distraction or rumination could result in further self-attack and lowering mood. However, despite awareness of this pattern of relating, it appeared

nonetheless difficult to break free from. These findings do then appear consistent with previous studies that have highlighted the paradoxical effect of avoidance on experiences of self-criticism and low mood (e.g. Blalock & Joiner, 2000).

When asked about possible relationships between modes and mood states, it was interesting that all participants most frequently suggested that their mood state had a causal influence on the mode. Whilst this may be the case, it is also possible that participants had internalised biomedical understandings of BD due to the dominance of these discourses. If this were relevant, such understandings might compound experiences of feeling that one has little control over variable mood and could contribute to the understandable use of avoidance as a way of coping.

4.2. Summary of Findings

An exploration of participant's responses to schema mode descriptions suggested that overall individuals appeared to identify with schema modes and described related emotional and behavioural states. There was also some suggestion from participant's accounts that they could move rapidly between these states (e.g. from feeling vulnerable and rejected to angry), perhaps representing what is theorised to be a 'flipping' between modes (Bamber, 2004). Participants also perceived there to be relationships between particular modes and mood states, and most commonly they suggested that changes to their internal state might activate particular modes. Findings suggested that some modes in particular (e.g. the *angry* and *vulnerable child* modes) may become more extreme during activated mood states and that processes such as rumination or experiential avoidance may seek to prolong experiences of modes more related to depressed mood states (e.g. the *punitive parent* mode).

Overall, the above findings might suggest that modes could have some descriptive value for service-users. However, qualitative analysis of the data also highlighted important related aspects of participant's experiences that were distinct from Young's mode descriptions, such as emotional responses associated with the *punitive parent* and *compliant surrenderer* modes, and the influence of wider systemic factors such as stigma on patterns of thinking, feeling and responding. Participants' responses also highlighted potential challenges to the current conceptualisation of modes and

how they are theorised to operate. The considerable overlap between modes, the changeability of modes, and the suggestion that thoughts, feelings and behaviours may not be activated synchronistically might all warrant further theoretical and empirical attention in establishing the descriptive value of modes.

4.3. Limitations

4.3.1. Limitations of data collection and research methods

This research was theory-led, which would have had a number of implications for the findings that should be considered. Firstly, participants were asked to comment on particular modes, and the interview schedule was designed around a theoretical understanding of modes. This potentially limited the discussion of other important experiences that could have had implications for the theory and practice of ST. Efforts were made not to ignore critical aspects of the data or to pay too much attention to some aspects over others during the analytic process. However, the generation of themes in this analysis should be considered in relation to a theory-led approach being taken.

Secondly, mode cards were presented to participants to initiate discussion about modes. It should be considered that whilst participants could relate their experiences to the mode card descriptions, this is likely to be the case for any person presented with a description of a mode. The Barnum effect (Meehl, 1956) demonstrates how individuals give high accuracy ratings to generic descriptions of personality that they believe describes them. This should be taken into consideration in the interpretation of any findings from this study.

The construction of the mode cards also requires further consideration. Efforts were made to provide a simplified summary of Young's modes so that descriptions would be accessible to participants. The language was adjusted for two modes in particular, which may have had more negative connotations associated with them (*overcompensator* and *impulsive/undisciplined child* mode). This was so as to enable participants to share experiences related to this mode if they did identify with it. For these reasons, the mode cards were constructed from two sources (Young, Klosko & Weishaar, 2003; Jacob, van Genderen, & Seebauer, 2015). Given the fact that modes are already multifaceted and seemingly overlapping constructs, this may

have contributed to the inability to conclusively code extracts of data that related uniquely to these modes. Additionally, these mode cards would be more difficult for future researchers to replicate.

Thirdly, the extent to which participants were able to report on their internal experiences in interviews was unknown (i.e. to what extent participants were aware of their moment-to-moment emotional and behavioural states). As discussed, this potentially impacted on participant's ability to report on some of the modes. The coding process therefore relied on the researcher and a co-rater independently coding interview transcripts according to mode descriptions, regardless of the mode participants were currently being asked about. It is acknowledged that I have not received training in ST and that this may have influenced how I conducted the research. For example, others may not agree with the mode card descriptions used, or decisions made as to whether participants were speaking about a particular mode. Efforts were made to control for this by using a co-rater during the data coding process, and having access to a supervisor trained in ST.

It should be noted that there were several instances where participants were being asked about the presented mode, but described experiences that both raters coding the data related to another. Whilst this could demonstrate a lack of insight into one's cognitive, behavioural and emotional states, this more likely reflected the overlap between modes already discussed, and the complexity of this construct.

Lastly, as mentioned in section 4.2.2., interviewing participants about schema modes in each mood state did result in the collection of relatively thin data in relation to the second research question and relied heavily on recall. A preferred method may have been to use a mood induction technique (Lobbestael, van Vreeswijk & Arntz, 2007), or to conduct a more in-depth interview on one mood state (e.g. 'euthymic') in a homogenous sample. Both were beyond the scope of this research, particularly since it was not possible to recruit a large enough sample of individuals in a similar enough mood state. Additionally, mixed states are common in those with a BD diagnosis and many (but not all) continue to experience low mood and/or anxiety between episodes (Judd et al., 2002; Shim, Woo, & Bahk, 2015). Therefore, such methods may not be realistic or meaningful.

4.3.2. Limitations of the mode construct

This research highlighted the challenges associated with researching a construct that consists of many elements. The overlap between modes was made visible in this research by the themes across modes appearing to relate to one another. Additionally, the broad nature of themes reflected that whilst there was some overlap between participants' experiences, there were also many differences. Regardless of diagnosis, it might be logical to assume that each individual has their own unique challenges and ways of coping and that each person's schema mode model (or formulation) would therefore be idiosyncratic.

The schema mode model has been viewed as a heuristic, open to development (Arntz & Jacob, 2013). Perhaps as a result, the number of modes (and sub-modes) is ever expanding to reflect nuances between different 'personalities' (Lobbestael et al., 2007). Whilst modes were initially developed to better conceptualise people's difficulties (Young, Klosko & Weishaar, 2003), it could be argued that the increasing complexity of modes and the seemingly indeterminable list of modes being formed, is having the opposite effect (Lobbestael et al., 2007). This raises questions about the utility of the mode construct, particularly whilst the multiplicity of any one personality and different ways of conceiving this might beg the question of how one can ever be 'right' about how personality is structured (Cooper & Cruthers, 1999). Modes perhaps have the potential to be a useful and practical therapeutic tool. However, when mode models are researched and constructed on the basis of diagnosis, one could argue that it similarly (and perhaps unhelpfully) classifies the complexity of human experience into broad categories.

Additionally, theories underpinning EMS and modes are based on Western assumptions and so one must question their cross-cultural relevance. For example, the assumption that modes reflect the 'fragmented self' and need integration may be at odds with cultures that hold the belief of a distributed notion of subjectivity, rather than models of a self-confined self. Additionally, ST is grounded in attachment theory, based on the assumption that one (female) primary caregiver raises a child. Cromby, Harper and Reavey (2013) argue that this obscures the diversity of early relationships and places emphasis on the importance of a small number of behaviours, which may not have relevance cross-culturally.

4.4. Evaluation of Research

The following sections attend to Yardley's (2000) principles for reviewing qualitative research and how these were addressed.

4.4.1. Sensitivity to context

This principle relates to the researcher's attempt to attend to relevant theory and literature, sociocultural settings and the perspectives of participants within the research context.

My experiences of working with service users with a diagnosis of BD informed my thinking in conducting my literature search. It was apparent to me that much of the literature surrounding current understandings of BD are biased towards biomedical assumptions. My teaching at UEL has made me increasingly aware of the relevance of perspectives pertaining to the impact of early adversity and social inequalities on the development of distress. This enabled me to attend to all relevant theory and bring complex arguments to an area where the impact of adversity remains under-reported. However, whilst bringing this to light in my literature review, I was careful not to allow this to uncritically influence my interpretation of the data, particularly whilst it was not possible to gather information about the early lives of participant's.

The interview was theory-led and structured around existing constructs. However, I asked open-ended questions in an endeavour to encourage dialogue around related issues relevant to participants. I was aware both during interview and analysis that men were the minority in my sample and that they tended to speak less actively about emotions. Being sensitive to social contexts and discourses about masculinity (for example, discourses equating masculinity with being strong and silent) (Johnstone et al., 2018) enabled me to think more critically about my interpretation of the data. I also considered my position as a young, white, female researcher and how this might have influenced the stories that participants told. This was particularly relevant when considering the potentially negative connotations attached to some modes. Culture is also likely to have shaped how experiences were spoken about in interview. The sample were from a range of cultural and ethnic backgrounds and although this was held in mind during analysis, I was aware that the development of themes across participants potentially led to this context being diluted.

4.4.2. Commitment and Rigour

Yardley (2000) suggests that commitment to research necessitates the researcher to have an in-depth engagement with the topic and demonstrate competency with the research method through data collection and analysis. This was not only my first encounter with qualitative research, but also with the topic of schema modes. Therefore, conducting this study required a process of both learning and thinking critically about schema theory as well as qualitative research.

The unique design of this study was an outcome of deliberation with my field supervisor as to the most appropriate methodological approach to take. Although it was initially considered in the research proposal that SMI data could act as a comparator to the data collected at interview and as a method of triangulation, the decision not to use this data in the analysis and write-up of this study was made on the basis of this principle. In considering the critical-realist epistemological positioning of the study and the aim of focusing on participant's experiences without attempting to search for a knowable truth (Braun & Clarke, 2006), it was thought that use of the SMI data could undermine what was in essence an exploratory study. The fact that the SMI data was collected and not used for the purpose of analysis does potentially highlight fallibility in the quality of this research according to Yardley's 'commitment and rigour' principle (2000), which suggests that the researcher should demonstrate competency with the research method from the initial stages.

4.4.3. Transparency and Coherence

This principle recognises the need for qualitative research to demonstrate transparency in the methods of obtaining data in order that the fit between the research question, research methods and the presentation of data can be examined. This research was unique in design, using descriptions of schema modes to generate discussion, but also relying on the researcher to determine which aspects of participants' experiences might be indicative of each mode. To highlight the transparency of the research process, examples of each stage of analysis have been provided as appendices. This includes an example of a coded transcript, matrix template, and of the codes and themes developed from data relating a schema mode (see appendices K – O). The attached appendices aim to give a coherent narrative of arrival to the interpretations made.

4.4.4. Impact and Importance

The importance of research can be assessed in relation to the objective of analysis and how it is intended to be applied (Yardley, 2000). The implications of this study are outlined in section 4.6. This research is of clinical relevance to people with a BD diagnosis and therapists working with them. Four of the seven participants interviewed for this study showed an interest in ST and asked whether it can be accessed in the NHS. Efforts will be made to disseminate the findings to participants and to wider academic forums to promote further research.

4.5. A Return to Self-Reflexivity

It has been important to reflect on my own experiences and motivations for conducting this research (Yardley, 2000). My therapeutic work initially alerted me to some of the limitations of current approaches for working with those with long-term difficulties and a BD diagnosis; particularly in considering difficulties with ongoing mood instability, relationships and occupational functioning. Hearing from other clinicians about the utility of ST with other long-standing difficulties made me consider whether integrative approaches such as ST might also have utility for other populations.

Throughout the research process, I was uncomfortable with having used a diagnostic label for recruitment. Specifically, this was based on reflections of my own experience of fluctuating mood and my belief that experiences labelled as mania or depression are ways of understanding distress that lies on a continuum of human experience. However, it was felt that a common frame of reference was necessary to begin a process of carrying out some potentially meaningful research. Throughout interviewing and writing, I have been careful with my use of language to avoid reifying individualising discourses. I hoped that this would enable participants to speak more freely about their experiences and the personal meaning that these have held.

Further reflections pertain to the issue of power. Participation in qualitative research can offer voice to those who are marginalised (Hutchinson, Wilson & Skodol Wilson, 1994). However, I was aware that my relative position of power as a TCP and researcher may have influenced what participants felt able to share in interview. I

endeavoured to offer a warm and non-judgmental approach to interviewing, which I hoped would encourage openness. I reflected that sometimes, it could feel as if participants viewed me as an expert, having the answer as to how to solve some of their distressing experiences. This made me wonder about the help that had previously been offered to participants, and their relationship to it.

Finally, I was aware that the experiences of those who had offered to participate were being captured over others who perhaps felt less able, and considered how this might relate to issues of power. Additionally, given the offer of a voucher for participating, I was aware that this further placed me in a position of power and was careful to ensure that participants knew that they could withdraw from the research at any time and did not need to answer all the questions.

4.6. Implications

The implications of the current study for future ST research are considered below. Given that ST research and practice is still in its infancy, the implications of these research findings are also considered in relation to working with individuals with a BD diagnosis using other approaches. The wider implications of this research are also considered.

4.6.1. Recommendations for Schema Therapy research

A number of limitations have been highlighted with respect to the present research. Alternative approaches, such as case series, would involve longer-term contact with participants and would allow for a deeper exploration of schema modes. This may be particularly relevant considering that an understanding of modes is usually developed over the course of therapy. It may have been particularly difficult to determine from participant's responses in a one-off interview whether modes descriptions could valuably represent their experiences. A case series with a larger sample of participants might provide an understanding of how modes operate across time and mood state and within context. Future research might also focus on exploring fewer modes, which would allow for the collection of richer data. In doing so, it might also be important to consider asking about early life experiences to explore any theorised associations between modes and childhood experiences.

The findings from this study raised numerous questions about the theoretical structure and operation of modes, that arguably require more empirical attention. This supports Smith's (2017) suggestion that research could benefit from looking afresh at the structure of modes, rather than attempting to describe them according to results of studies using the SMI. He argues, for example, that a structural exploration of modes could begin to take place through examining the relationship between related concepts such as 'Internal Working Models' (IWMs) and EMS/modes in order to support their theoretical grounding (see Smith, 2017).

Furthermore, given that the number of modes is ever increasing and numerous methodologies have been used to assess them, there may be a need for ST researchers to identify a research program and develop questions that can best assess the utility of the mode construct. This conceptualisation could guide researchers in identifying, for example, the best methods to test the mode concept and how one might decide on the basis of their research whether modes are applicable and how many modes might be relevant to any individual.

Finally, the variation of individual experiences within this sample highlighted that conducting research based on diagnostic categories may lack utility, particularly if ST has the potential to be a transdiagnostic approach. Indeed, a number of the thoughts, emotions and behavioural responses described by participants also have relevance to a number of other diagnoses (e.g. depression, BPD). Future research may therefore benefit from alternative sample selection methods.

4.6.2. Implications for clinical practice

The findings suggest that interventions which focus on emotional regulation and interpersonal responding between episodes of extreme mood disruption may be of use to this population. Some participants appeared sensitive to emotional stimuli, resulting in intense feelings of rejection and anger. With further research, such interventions might include ST. However, currently some studies suggest that Dialectical Behavioural Therapy (DBT) (see Linehan, 1993) may also have utility for those who experience difficulties with emotion regulation, including individuals with a diagnosis of BD (e.g. Goldstein et al., 2007; Van Dijk, Jeffrey, & Katz, 2013). DBT also draws on techniques such as mindfulness, which develops one's capacity for awareness and acceptance of distressing thoughts and feelings and the ability to

disengage from them, without trying to change them (Strange et al., 2012). This might be a useful technique for reducing processes such as avoidance and rumination, which this research suggests might prolong periods of self-attack.

The study also highlighted what appeared to be high levels of self-criticism in this sample. Lowens (2010) suggests that 'Compassionate Mind Training' (CMT) (see Gilbert, 2000; Gilbert & Irons, 2005), which directly focuses on self-criticism, might be a useful addition to interventions when working with those with a diagnosis of BD. DBT also focuses on developing self-compassion (Linehan, 1993).

Some participants described how family members could have negative responses to their displays of emotion. 'High Expressed Emotion' (EE) environments are thought to contribute to relapse (e.g. Barrowclough & Hooley, 2003), and signs of interpersonal rejection from one's family could be internalised and contribute to subsequent mood dysregulation. These findings might highlight the importance of including wider systems in interventions if appropriate, perhaps by considering familial affective reactions to mood instability and supporting families to develop relevant coping strategies (Miklowitz, 2007).

Findings also highlighted the impact that stigma might have on individuals' experiences of emotion and engagement in meaningful interpersonal relationships. This demonstrates the importance of clinicians asking about experiences of stigma and discrimination and the impact of these, and incorporating this into formulations. The Power-Threat-Meaning (PTM) framework (Johnstone et al., 2018), may be considered for use in this process. This framework ensures focus on wider influences factors such as stigma, power and culture and explicitly emphasises the need to change societal norms and socially available discourses to reduce human distress.

Approaches such as ST that directly consider the role of adversities in influencing experiences of distress, are arguably also worth further attention. An increasing amount of research indicates links between experiences typically associated with BD and early adversity (see Aas et al., 2016). However, this is in its infancy. Further research would be required to clarify whether an approach like ST could offer an alternative intervention to this population. Should ST be considered a useful intervention, this research highlights the need for therapists to be flexible and

tentative in their use of modes to conceptualise how clients might relate to themselves or others. Whilst clients might relate to mode descriptions or find a mode formulation to be a useful framework, these descriptions should not be used at the expense of understanding any individual's unique experiences.

4.6.3. Wider implications

This research highlighted the impact of stigma and power on experiences of shame, particularly when participants felt that they had not achieved according to societal standards. This implies an important role for clinical work, beyond that of individual approaches. An effective way of challenging stigma might be through raising awareness of mood instability and challenging the use of illness terminology. Additionally, there is perhaps work in preventing the continuous reinforcement of narratives that emphasise the role of internal characteristics such as 'motivation' for gaining success, which likely perpetuate feelings of shame when attempts to achieve are not linked to success (Friedli & Stern, 2015). Such dominant constructions are often shaped by powerful groups and therefore attain credibility in society, making them difficult to challenge (Foucault, 2001). However, resistance might take the form of using clinical skills at wider levels to thicken narratives that are too often subjugated. For example, what often remains hidden is that there is much more potential for experiences of shame in societies where one's worth is judged in relation to economic achievement and where there are such large inequalities of income (Wilkinson & Pickett, 2010).

4.7. Conclusions

This exploratory pilot study offered a methodology for exploring the descriptive value of schema modes, which has been critically reviewed. Participants responses to schema mode descriptions suggested that overall they identified with schema modes and described related emotional and behavioural states. Participants' accounts suggested that experiences of being demanding of oneself, self-attack, anger, and feelings of vulnerability were all key features of their experience, but could vary according to mood state. Given that there are so few qualitative studies exploring the experiences of those with a BD diagnosis, these findings might begin to meaningfully contribute to the limited understanding of BD that we hold.

Qualitative analysis also revealed distinctions between mode descriptions and participant's experiences and highlighted issues with the current conceptualisation of modes and how they are thought to operate. This has a number of implications for considering the descriptive value of schema modes, as well as for future research. However, exploring participant's responses to mode constructs did highlight the importance of focusing interventions not solely on managing or preventing relapse, but on underlying experiences of shame and on one's interpersonal relationships. The impact of stigma and putting pressure on oneself to achieve could also benefit from further attention both in clinical practice and at wider levels.

The schema mode model may have potential as a useful therapeutic tool if used flexibly and not at the expense of understanding any individual's unique experience. However, researching the mode construct is in itself a complex process. Some recommendations for future research in this area have been made.

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6. APPENDICES

APPENDIX A - Early Maladaptive Schemas (Young et al., 2003, p.14-17)

1) Disconnection and Rejection

- 1) Abandonment/Instability – the perceived instability or unreliability of those available for support and connection.
- 2) Mistrust/Abuse – the expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage.
- 3) Emotional Deprivation – the expectation that one's desire for a normal degree of emotional support will not be adequately met by others.
- 4) Defectiveness/Shame – the feeling that one is defective, bad, unwanted, inferior, or invalid in important respects or that one would be unlovable to significant others if exposed.
- 5) Social Isolation/Alienation – the feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

2) Impaired Autonomy and Performance

- 6) Dependence/Incompetence – the belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others.
- 7) Vulnerability to Harm or Illness – exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it.
- 8) Enmeshment/Undeveloped Self – excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development.
- 9) Failure – the belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers in areas of achievement.

3) Impaired Limits

- 10) Entitlement/Grandiosity – the belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction.

11) Insufficient Self-Control/Self-Discipline – pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals or to restrain the excessive expression of one's emotions and impulses.

4) Other-Directedness

12) Subjugation - excessive surrendering of control to others because one feels coerced – submitting in order to avoid anger, retaliation, or abandonment.

13) Self-Sacrifice - excessive focus on voluntarily meeting the needs of others in daily situations at the expense of one's own gratification.

14) Approval-Seeking/Recognition-Seeking - excessive emphasis on gaining approval, recognition, or attention from other people or fitting in at the expense of developing a secure and true sense of self.

5) Overvigilance and Inhibition

15) Negativity/Pessimism – a pervasive, lifelong focus on the negative aspects of life while minimising or neglecting the positive or optimistic aspects.

16) Emotional Inhibition - the excessive inhibition of spontaneous action, feeling, or communication, usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses.

17) Unrelenting Standards/Hypercriticalness - the underlying belief that one must strive to meet very high internalised standards of behaviour and performance, usually to avoid criticism.

18) Punitiveness – the belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards.

APPENDIX B - Mode Descriptions and Associated EMS

Child Modes (from Young, Klosko and Weishaar, 2003; p.273)

<i>Child Mode</i>	<i>Description</i>	<i>Common Associated EMS</i>
Vulnerable Child	Experiences fear, sadness, and helplessness, when associated schemas are activated	Abandonment, Mistrust/Abuse, Emotional Deprivation, Defectiveness, Social Isolation, Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self, Negativity/Pessimism.
Angry Child	Reacts angrily in response to the perception of core needs not being met or being treated unfairly by others	Abandonment, Mistrust/Abuse, Emotional Deprivation, Subjugation (or, at times, any of the schemas associated with the Vulnerable Child).
Impulsive/ Undisciplined Child	Acts impulsively to gain immediate pleasure with little concern for others needs or feelings (not related to attempting to meet core needs)	Entitlement/Grandiosity, Insufficient Self-Control/Self-Discipline.
Happy Child	Feels content, connected, loved and satisfied	Absence of activated dysfunctional schemas.

Parent Modes (from Young, Klosko and Weishaar, 2003; p.277)

<i>Dysfunctional Parent Mode</i>	<i>Description</i>	<i>Common Associated EMS</i>
Punitive/Critical Parent	Restricts, criticizes, or punishes the self or others.	Subjugation, Punitiveness, Defectiveness, Mistrust/Abuse (as abuser).
Demanding Parent	Sets high expectations for self and others and pushes self or others to achieve them	Unrelenting Standards, Self-Sacrifice.

Coping Modes (from Young, Klosko and Weishaar, 2003; p.275)

<i>Dysfunctional Coping Modes</i>	<i>Description</i>
Compliant Surrenderer	Copes by complying with and submitting to the schema.

Detached Protector	Withdraws from the pain of the schema by disconnecting, isolating oneself, and behavioural avoidance.
Overcompensator	Adopts a coping style of control and counterattack, behaving in ways that disprove the schema. This may play out in attacking or mistreating others, or may involve semi-adaptive means such as workaholism.

APPENDIX C – Schema Mode Inventory (SMI)

Description of the SMI – Short version

The SMI (Young et al., 2007) is a self-report measure containing 124 items. The psychometric properties of the SMI have only been investigated in one large scale research study to date, but it is reported to have good psychometric properties (Lobbestael, van Vreeswijk Spinhoven, Schouten & Arntz, 2010). The SMI is considered to demonstrate good reliability and validity, and is therefore concluded to be a valuable measure of use for mode assessment in ST practice and research (Lobbestael, 2012). The SMI has not been empirically tested using a population of people with a BD diagnosis.

Administration and use of the SMI

The SMI was administered to each participant at the end of the interview process, and took approximately 20 minutes to complete. Participants were asked to complete the measure based on how often in general they agreed with each item whilst in their current mood state. Although administered, it was not consistent with the study's final research aims to use the SMI data, nor was it possible to use the SMI data sufficiently for its original intended purpose of methodological triangulation. Although therefore not included as part of the the analysis for this study, this appendix offers a comparison of participants SMI scores against norms from a non-clinical adult population (see tables 1 & 2), should this be of interest for other researchers and academics working in this area. Out of interest, consideration has also been given to any discrepancies between each participants SMI scores and their qualitative data

SMI norms are presented in the table below (Table 1.). Ratings on the SMI range from 'very low' to 'severe' when compared to a non-clinical population, and reflect the extent to which an individual is likely to experience a schema mode.

SMI norms and participant SMI scores

Mode	Abbr	Your Score	Very Low	Average	Moderate	High	Very High	Severe
Child Modes								
Vulnerable Child	VC		1	1.47	1.98	3.36	4.47	6
Angry Child	AC		1	1.81	2.29	3.09	4.03	6
Enraged Child	EC		1	1.20	1.49	2.05	2.97	6
Impulsive Child	IC		1	2.15	2.68	3.05	4.12	6
Undisciplined Child	UC		1	2.27	2.87	3.47	3.89	6
Contented Child (Reversed)	CC		6	5.06	4.52	2.88	2.11	1
Avoidant Modes								
Compliant Surrenderer	CS		1	2.51	3.07	3.63	4.27	6
Detached Protector	DP		1	1.59	2.11	2.95	3.89	6
Detached Self-Soother	DS		1	1.93	2.58	3.32	4.30	6
Overcompensating Modes								
Self-Aggrandizer	SA		1	2.31	2.90	3.49	4.08	6
Bully & Attack	BA		1	1.72	2.23	2.74	3.25	6
Parent Modes								
Punitive Parent	PP		1	1.47	1.86	2.75	3.72	6
Demanding Parent	Dpa		1	3.06	3.66	4.26	4.86	6
Healthy Adult Modes								
Healthy Adult (Reversed)	HA		6	5.16	4.60	3.60	2.77	1

Table 1. SMI norms

Participant	current mood state	Demanding Parent	Punitive Parent	Vulnerable Child	Angry Child		Impulsive/Undisciplined Child		Compliant Surrenderer	Detached Protector		Overcompensator	
					Angry Child	Enraged child	Impulsive Child	Undisciplined Child		Detached Protector	Detached self-soother	Self Aggrandizer	Bully and Attack
Sharon	Euthymic	Moderate	average	Moderate	Moderate	Moderate	High	Moderate	Very low	Average	Moderate	Average	High
Zehra	Low-Euthymic	Very low	moderate	Moderate	Moderate	Very low	Moderate	Very low	Very low	High	High	Average	Very low
Eymen	Low	Average	very high	Very high	High	Moderate	Very low	Average	Average	High	Moderate	Average	Moderate
Michael	Euthymic	Very low	very low	Average	Very low	Very low	Very low	Very low	Very low	Very low	Very low	Very low	Very low
Basima	Euthymic	Moderate	moderate	Moderate	Moderate	Moderate	High	Moderate	Average	Average	High	Very low	Average
Lucy	Low-Euthymic	Average	average	High	Very low	Very low	Very low	Moderate	Average	Moderate	Very low	Average	Average
Amy	Hypomanic	Average	high	Moderate	High	Moderate	High	Average	Average	Average	Moderate	Average	Very low

Table 2. Participant SMI scores

Commentary on participants SMI Scores

Participant SMI scores are listed in the table above (Table 2.). The sections below offer a commentary on each participants SMI scores, and consideration of any areas of discrepancy with their qualitative data. The SMI scores and comparison to qualitative data is solely for the purposes of interest to the reader, and have not been considered in the analysis or conclusions of this exploratory piece of qualitative research.

Sharon

Sharon's score on the *punitive parent* mode reflected an 'average' rating. In interview she described being punitive of herself, but related to this more in a depressed mood state, which may explain the discrepancies between scores. Another discrepancy was Sharon's 'moderate' score on the *vulnerable child* mode, as in interview she did not identify with this mode in her current mood state. Interestingly, Sharon described using anger as a way of protecting herself against emotions such as sadness (typically associated with the *vulnerable child* mode) and had 'moderate' scores on both the *angry child* and *bully and attack* modes. A final discrepancy might be Sharon's 'very low' score on the *compliant surrenderer* mode, though she only described one relationship where she could be submissive. However, a 'very low' score on this mode might reflect a defense against Sharon seeing herself, or being seen by others, as compliant or inferior.

Zehra

Zehra's 'very low' score on the *demanding parent* mode reflects the first discrepancy between her scores and her description of herself as a "perfectionist" in interview. Zehra's low score on this mode might reflect her active attempts to reduce her high standards over time. Additionally, Zehra implied that her current low mood state was influencing her ability to perform tasks to her desired standard: "Now my mental health effects that as well. If I don't want to do anything, I am not doing it" (148-149), perhaps suggesting that 'demandingness' might appear more in elevated mood states. A further discrepancy was Zehra's 'moderate' score on the *angry child* mode, as she did not describe anger as problematic in interview. This might reflect a reluctance to discuss experiences of anger in this context. Similarly to Sharon, Zehra also

scored 'very low' on the *compliant surrenderer* mode, and again suggested in interview that she might be actively trying to resist this way of being.

Eymen

Eymen also expressed during interview that he could set high standards for himself, but had an 'average' score on the *demanding parent* mode. Eymen implied that his low mood state was currently preventing him from pushing himself to achieve: "Right now I'm definitely a quitter. I'm not in the mood to persevere or try anything out at the moment" (134-135). The suggestion that being demanding of oneself was related to more elevated mood states and Eymen's description of his current mood state as 'low', might then explain his 'average' score on this mode.

Michael

Michael scored as 'very low' on all schema modes apart from the *vulnerable child* mode, for which he scored within the average range. During interview, Michael reported few experiences that appeared to fit with mode descriptions. This was with the exception of the *vulnerable child* and *detached protector* modes. It could be hypothesised that Michael's low scores on the SMI and his emotional detachment during interview were a reflection of these modes operating in the room, resulting in a more defended representation of his experiences. Therefore, the SMI might not be an accurate representation of Michael's experiences.

Basima

Basima scored moderately on the *demanding* and *punitive parent* modes. However, in interview, the majority of her statements were coded both by the researcher and the other rater as representing either *angry*, *vulnerable* or *impulsive child* modes, which she also scored moderately on. This discrepancy may represent the complexity of individual experiences and the limitations of attempting to conceptualise them as single 'modes' for the purposes of research. For example, at interview, Basima described feeling 'badly' that her sister had been let down in relation to being asked about the *punitive parent* mode. However, she then referred to blaming her husband for the situation and feeling angry with both him and her sister. Whilst this was coded as *angry child* mode and was not consistent with the *punitive parent* mode description, it is

likely that there are a range of thoughts and emotions unique to Basima's experience, that might not be captured by a single mode.

Lucy

Lucy's 'average' scores for both the *punitive* and *demanding parent* modes was surprising as she described a tendency to be self-critical throughout the interview. Lucy did however suggest that frequently she coped with self-critical thought through avoidance, and this corresponded with her 'moderate' score on the *detached protector* mode. The *demanding parent* mode again appeared to be more relevant to Lucy in a hypomanic mood state, and during interview she described how currently low energy was preventing her from pushing herself to achieve, therefore providing a possible explanation for this discrepancy: "What it is [taking Lithium], is it's like, it pulls me down. It's taken away that energy that I had" (312-314).

Amy

Amy's average score on the *demanding parent* mode appeared inconsistent with her reports during interview. However, for Amy, it was apparent that anticipation of not meeting standards was closely linked to being punitive of herself and she scored highly on the *punitive parent* mode, perhaps suggesting that this was more prevalent for her. Amy's moderate score on the *vulnerable child* mode was also surprising, as she referred to recent situations which had triggered feelings of vulnerability. However, in each of these descriptions, it was also apparent that this was associated with strong feelings of anger. One possibility is that anger was felt more intensely than feelings of sadness or abandonment in what she described as her hypomanic mood state, thus she scored higher on these items.

Comparison across participants

When comparing the sample as a whole, it is interesting to note that few participants scored in the 'high' or 'very high' range for any of the schema modes. This might reflect the changeable emotional states of those with mood related difficulties and most participants taking part in the study during a relative period of wellness.

It was notable that most participants had 'moderate' or 'high' scores on both the vulnerable and angry child modes, which may suggest a relevance of these modes regardless of mood state. All but one of the participants who had 'moderate' or 'high' scores on the angry child mode, also had higher scores on the impulsive child mode. Some of the items relating to the impulsive child mode on the SMI are non-specific (e.g. Item 69: "I act first and think later"), and high scores on such items could, for example, be reflective of how participants felt that anger could be difficult to control.

Another comparative finding was that all participants all scored between very low and average on the *compliant surrenderer* mode. One possibility is that this reflects a resistance towards being viewed by the self or others as very compliant or inferior.

It should be noted that it was not possible to identify any clear patterns between SMI scores and mood states. This was despite participants making the same associations between particular mood states and modes (e.g. being more punitive when in a lower mood state). An inability to draw patterns from the SMI scores is likely to be representative of the small sample of participants who were in varying mood states and between episodes of major mood disruption at the time of completing the SMI.

It was evident that participants did vary in their consistency between interview responses relating to their current mood state and SMI scores. This may have been influenced by a number of factors including current mood state, rapport with the researcher, age, gender or culture.

APPENDIX D - Information Sheet for Healthcare Professionals



SEEKING PARTICIPANTS FOR RESEARCH STUDY

Research Title: Exploration of Schema Modes in Bipolar Disorder

I am seeking to recruit participants for my doctoral thesis study. This study aims to explore whether people with a diagnosis of bipolar disorder describe being in different modes of functioning (i.e. have different combinations of thoughts, emotions and ~~behavioural~~ responses) at different times. If so, what kind of things affect these modes of functioning and cause them to change? Participants will be asked to take part in an interview and complete a questionnaire. Participation in the study will last approximately 1.5 hours. Participants will be given a £10 Love2Shop voucher for their time.

I am seeking to recruit approximately 8-10 participants who meet the following criteria:

- A. Has a diagnosis of type I bipolar disorder (i.e. has had at least one manic episode accompanied by psychotic symptoms, and also experiences episodes of depressed mood)**
- B. Has not also been diagnosed with any additional major psychiatric conditions, with the exception of anxiety (given its prevalence)**
- C. Is aged 18 or over**
- D. Understands and speaks English**
- E. Is considered by their clinical team to be in a mentally stable condition and to have the ability to give informed consent**

If you have anyone on your caseload at the [REDACTED] who meets the above criteria, I would be extremely grateful if you could ask for their consent to be contacted by the researcher for more information about the study.

Please ask for:

- 1) Their preferred method of contact (e.g. email, telephone)
- 2) Their contact details
- 3) Their preferred day of week and time of day to be contacted

Note that prior to commencement of each interview I will discuss with you the service user's emotional state, to check that they are at present stable. I will also check how the service user responded in recent interviews to any questions that may have been upsetting: if there are any indications that the service user may not be stable, I will not proceed.

After the interview I will speak to you and share information concerning any distress that may have been displayed by the service user. Whether the service user appeared distressed or not, I will ask you to check directly with the service user.

This study is being carried out under the supervision [REDACTED] Clinical Psychologist. We hope that this research will help us to better understand experiences of bipolar disorder and how existing therapies can be appropriately modified for working with this client group. Recruiting for research studies can be challenging and I am therefore very grateful in advance for your support with this.

Please do not hesitate to email myself [REDACTED] securely for more information or about the study; or with the details of any potential participants who have consented to being contacted.

Your support with recruitment is very much appreciated!

[REDACTED]

APPENDIX E - Participant Information Sheet



Project ID: [REDACTED]

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

UNIVERSITY OF EAST LONDON

The Principal Investigator

Zoe Engledew, [REDACTED]
[REDACTED]

Information Sheet about a Research Study

This letter is giving you some information to help you think about whether you would like to take part in this research study. The study is part of my Professional Doctorate in Clinical Psychology at the University of East London.

Title of research study

An exploration of schema modes in Bipolar

What is the study about?

The aim of this study is to interview people who have been referred to the [REDACTED] about their experiences. I would like to investigate whether there are particular ways of responding to or coping with serious mental health problems. It is hoped that this study will help to develop psychological therapies.

The completed study will be written in the form of an academic thesis. I may use the research to write more articles that might appear in academic or practice journals.

Why am I being asked to take part?

As you have been referred to the [REDACTED], you might have had some experiences commonly associated with bipolar and I believe that speaking directly to people who have had these types of experiences is the best way to understand it.

What am I being asked to do?

I am interested in meeting with you for an interview that would last for about one hour. I would ask a number of questions and make an audio recording of the interview, which I would type up afterwards. After the interview I would also ask you to complete a questionnaire, which would take 20-30 minutes.

What are the benefits of taking part?

In being interviewed you will have the chance to speak about your experiences and give your understanding in relation to these. You will also be helping to give researchers and professionals some understanding about bipolar and therapies that could be developed to help people in similar positions to you in the future.

Where would it take place?

Interviews would take place in a private room at the [REDACTED] offices.

Project ID: [REDACTED]

What information will you have about me and how will you keep it safe?

I would record each interview using an audio recorder. Only I would listen to the recordings and type them up into transcripts. Any names that were mentioned and anything that would make you or anyone else identifiable would be changed in the transcript. As this research study is part of my University course, two supervisors will be supporting me with the study and I will be discussing information from the interviews and questionnaires with them. The typed transcript will be read by my research supervisor [REDACTED], a Clinical Psychologist at [REDACTED] and may be read by my other research supervisor [REDACTED], Clinical Psychologist at the University of East London. The examiners who test me when the thesis is assessed may request to see the transcript. No one else will have access to the transcript or questionnaire.

The final thesis will include a small number of quotes from interviews. I will make sure that these quotes do not identify who you are or anyone you are talking about.

The audio file, transcript and answers to the questionnaire will be saved on a computer that is password protected, in separate password protected files. Any paper-based information (consent forms, questionnaires) will be kept in locked drawers or filing cabinets on NHS premises.

How long would you keep my information for?

All information (audio recording, written transcript, questionnaire responses) will be kept for five years following completion of the thesis, and then destroyed. During the five years, the information might be used for additional articles or publications based on the research.

Are there any risks in taking part?

There are no risks or dangers involved in taking part, although it is possible you might get upset during or after the interview, if you were talking about difficult experiences. If you did get upset, there are some ways I could offer support to you:

- People who take part in the interview are welcome to approach me about any distress they experience. I would not be able to give advice or offer counselling, but I would be available to think about how you are feeling in relation to the interview. We might think together about who might be able to help and who you might like to share the information with
- If I notice that you appear to be upset, I might check this out with you after the interview.
- After the interview, I would provide information about support you could access if you feel you need it.
- You could also contact a member of your healthcare team at [REDACTED] for support if you needed to.

I have a responsibility to consider the safety of the people who take part in the study. If I am concerned about the safety or well-being of yourself or others, I am legally required to inform someone who may need to know or help. I will discuss this with you first, where possible. There are two main situations where this might happen:

- 1) If you tell me about any illegal activity you have taken part in.
- 2) If I am worried about your safety and well-being or the safety and well-being of other people linked to you.

Project ID: [REDACTED]

What if I decide to take part, but then change my mind?

You can change your mind at any point. You do not have to give a reason why and you will not be at a disadvantage for changing your mind. During the interview, if you do not feel comfortable answering a particular question, you do not have to answer it. If you would like us to stop the interview, we can do this at any point.

I have some questions about the study; can I contact you?

Yes, I am happy to answer your questions. You can contact me by email or telephone; my contact details are at the top of this letter.

I would like to take part. What do I do now?

You might have already agreed for a member of your healthcare team to pass me your contact details; in this case you will hear from me soon. If you did not agree for your contact details to be given to me, but would like to talk to me about possibly taking part, you can contact me by email or telephone (contact details at the top of this letter). Or you can speak to a member of your healthcare team at [REDACTED] they will ask you for a contact phone number or email address so I can contact you. If, once we have spoken, you agree to participate I will notify your healthcare team of this, provided you agree to this. On the day of the interview, I will give you a consent form to read and sign before we start. You will have the chance to ask more questions if you need to before you decide whether to sign the form.

What if I'm not happy with how the study has been conducted?

If you have any questions or concerns about how the study has been conducted, please contact the study's academic supervisor [REDACTED], School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 0208 223 4021. Email: [REDACTED])

OR

Chair of the School of Psychology Research Ethics Sub-committee: [REDACTED] School of Psychology, University of East London, Water Lane, London E15 4LZ.
[REDACTED] Email: [REDACTED]

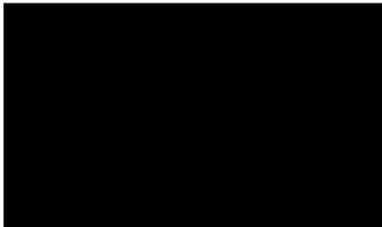
Thank you for reading this letter.


Yours sincerely,

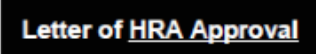
[REDACTED]
[REDACTED]
[REDACTED]

APPENDIX F - Ethical Approval

Below is the first page of the NHS Ethics approval letter received on 26th September 2017.







Study title: An Exploration of Schema Modes in Psychosis (including Bipolar conditions).

IRAS project ID: 222790

Protocol number: N/A

REC reference: 17/LO/1407

Sponsor University of East London

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

APPENDIX G - Participant Consent Form



IRAS ID: [REDACTED]

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: An exploration of schema modes in Bipolar conditions

Name of Researcher: [REDACTED]

1. I confirm that I have read the information sheet dated 21/09/2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I agree to my healthcare team being notified that I am taking part in this study.

☐

4. I understand that relevant sections of my medical notes may be looked at by individuals from my healthcare team at [REDACTED]

☐

_____, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

5. I understand that data collected during the study may be looked at by individuals from the University of East London and regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

☐

6. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Name of Person

Date

Signature

taking consent

(One copy to be kept by the participant, and one copy by the researcher)

APPENDIX H - Interview Schedule

Interview Schedule

Introductions and engagement

Agree approximate length of interview, can take breaks, ice breaker questions e.g. how was your journey here? Ask if they would like a summary of the research.

Exploration of bipolar experiences / extremes of mood

Bipolar can be experienced in different ways. Lots of people who are given a bipolar diagnosis describe experiencing extremes in their mood states, so they may spend periods of time feeling very depressed or have periods of time where they feel elated or over active. Some people may have unusual experiences during their highs such as hearing voices that other people can't hear, or they may develop strong beliefs that are not accepted by other people. Some people also describe mixed mood states where they experience some of the aspects of mania (for example, excitement and a rush of new and exciting ideas) with some of the aspects of depression (perhaps restlessness, agitation, anxiety, irritability or even suicidal thoughts). Everyone's experience of bipolar is unique.

Do these descriptions fit with your experiences? Have you experienced being both manic and depressed?

How would you describe your current mood state?

Questions specific to Young's modes

Descriptions of each mode will be typed onto separate cards. Participants will be handed one card at a time, given time to read it (the researcher will offer to also read it out) and ask questions for clarity, then asked the following questions.

'I am going to tell you a little bit about the way that many people's difficulties are viewed in a therapy called Schema Mode Therapy, and I'm going to ask you to tell me if you think it fits for you. In Schema Mode Therapy it is believed that everyone experiences themselves differently at different moments. While we may feel very healthy and relaxed in one moment, we may feel vulnerable and sad in another. In another situation we may feel nothing. Schema Mode Therapy describes these different experiences as modes. We can be in one mode for a while, but then change over into another mode, depending on the situation.

I have descriptions of a few modes written on these cards. I am going to give you a card to read, and I will also read it out to you. I will then ask you some questions about it. Then I will give you the next card. Do you have any questions?

PRESENT MODES ON CARDS:

[Demanding Parent]

In this mode, you might push yourself to do your best in everything. You might feel under permanent pressure to achieve.

You might try to never make a mistake, and if you don't manage to do everything in the 'right' way, you might be very critical of yourself.

You might not allow yourself to relax or have fun until all the work is done.

[Punitive Parent]

In this mode, you might devalue and/or hate yourself most of the time; feel ashamed of yourself, your feelings and needs; or think you cannot expect anyone to spend time with you.

You might feel that you deserve to be punished. You might have the urge to punish and/or hurt yourself (e.g. cut yourself).

You might not be able to forgive yourself.

You might believe that you are not allowed to do pleasant things like other people, because you think you are bad.

[Vulnerable Child]

In this mode, you might often feel completely alone, feel weak and helpless, or feel that nobody loves you. You might feel frightened. You might feel sad, abandoned, or anxious without a particular reason.

[Angry Child]

In this mode, you might feel anger and rage. When you get angry you might not be able to control yourself. You might become furious and shout, or have violent thoughts and impulses. This may cause serious problems in your life.

[Impulsive/Undisciplined Child]

In this mode, you might believe that you can do what you want, no matter how other people feel or think about it. You might break the rules and regret it afterwards. You might think that normal rules don't apply to you.

You might find it hard to stop yourself from doing something you want to do, even if you know you should not do it.

You might feel strong and powerful, and it can be a great feeling to put others in their place, but afterwards you might feel bad in some way.

[Surrender Coping]

In this mode, you might think about the needs of others, not your own. You might allow others to treat you badly. You might do things you don't actually want to do, because others want or demand it. You might try to please other people to avoid conflict.

[Detached Protector Coping]

In this mode, you might shut off your emotions because it is otherwise too painful. You might feel numb or empty. You might avoid things you find difficult, such as conflicts with others, social contact, negative emotions, or thinking about yourself and your problems.

You might drink alcohol, take drugs, eat, or distract yourself to avoid certain emotions.

[Overcompensating Coping]

In this mode, you might act the opposite to how you actually feel. You might behave very self-confidently, try to impress others, or act in a very dominant or assertive way. Despite acting this way, it might be that underneath you feel insecure or helpless.

You might be very critical about what others do or don't do.

If you are criticised, you might jump to your defence. You might blame others.

Questions (to ask about each of the modes):

- 1) Do you ever feel like this or experience anything like this?
- 2) Can you tell me what this is like?
Recent example?
Prompt: what do you feel like/what do you do when that part of you predominates? – how strong/intense is this feeling/urge/behaviour – whatever they have described?

Prompt: what kinds of thoughts tend to come up when you are in that mode?
– is there anything that you do in response to these thoughts?

3) How often do you tend to experience this?

4) Does anything in particular seem to trigger this off / what seems to get it going?

Prompt: Internal triggers (e.g. thoughts, images, memories, feelings) or external triggers (e.g. arguments)

5) How long does this mode last/how long does this mode go on for?

Prompt: How does it stop / what kinds of things might make it stop?

6) We have discussed several modes or states that you experience in your current mood state. What about when you are depressed/manic/mid state? Do you experience any of these modes then?

Prompt: Is the mode experienced differently in any way when you are depressed/manic?

Prompt: Are there any changes to your depression/mania when you go into this mode?

Prompt: Do you think there is a relationship between these modes and your mood state? Does being manic or depressed increase or decrease the likelihood of one of these modes happening?

7) We have discussed several modes. Do you think there are others you experience in any mood state (i.e. mid, manic, depressed)? What are these like?

Additional prompts

- What was that like for you?
- Can you tell me more about that?
- Can you give me an example?
- What are some of the ways you [don't feel good about yourself]?
- How did it make you feel when [she] used to [talk to you] that way?

Debriefing: "How do you feel about the conversation we've just had? Do you have any questions? Here are some contact details for support organisations if you feel you'd like to talk to someone later on."

APPENDIX I - Mode Cards

<p>1</p> <p>You think you're bad and/or dislike yourself most of the time.</p> <p>You feel that you deserve to be punished.</p> <p>You might have the urge to punish yourself (e.g. by harming yourself) or not allow yourself to do pleasant things.</p>	<p>2</p> <p>You push yourself to do your best in everything.</p> <p>You feel under pressure to achieve.</p> <p>You try to never make a mistake, and if you do you're critical of yourself.</p> <p>You don't allow yourself to relax until all the work is done.</p>
<p>3</p> <p>You often feel completely alone, weak and helpless, or that nobody loves you.</p> <p>You might feel frightened, sad, abandoned, or anxious without a particular reason.</p>	<p>4</p> <p>You feel anger and rage.</p> <p>When you get angry you cannot control yourself.</p> <p>You become furious and shout, or have violent thoughts and impulses.</p> <p>This causes serious problems in your life.</p>

<p>5 You believe that you can do what you want, no matter how other people feel or think about it.</p> <p>You find it hard to stop yourself from doing something you want to do, even if you know you should not do it.</p> <p>You feel strong and powerful, and it can feel good to put others in their place, but afterwards you might feel bad in some way.</p>	<p>6 You think about other people's needs, not your own.</p> <p>You do things you don't want to do, because others want or demand it.</p> <p>You allow others to treat you badly.</p> <p>You try to please others to avoid conflict.</p>
<p>7 You avoid things you find difficult, such as conflicts with others, social contact, painful emotions, or thinking about yourself and problems.</p> <p>You feel numb or empty.</p>	<p>8 You act the opposite to how you actually feel. You might behave very self-confidently, assertively, or try to impress others. Underneath you might feel insecure or helpless.</p> <p>You are very critical about what others do or don't do.</p> <p>If you are criticised, you jump to your defence. You might blame others.</p>

APPENDIX J - Transcription Notation System (adapted from Braun & Clarke, 2013)

Feature	Notation and explanation
Identity of speaker	Letter, followed by colon (e.g. I:). I: is used for when interviewer is speaking, P: is used for when participant is speaking. New line used every time a new speaker starts. First word of each new turn of talk in a capital letter.
Laughing	[laughs] signals laughing by person speaking.
Pausing	[.] signals a pause that is significant but brief (i.e. a few seconds). [number] indicates a longer pause, e.g. [5] for a 5 second pause
Brief interjections	If person interjects when other person is speaking, present in < >, e.g. 'I will ask you about your experiences of this <ok> before'.
Inaudible speech	[inaudible] for speech and sounds that are completely inaudible.
Non-verbal utterances	Render phonetically and consistently common non-verbal sounds uttered by participants, e.g. 'um', 'er', mm', 'mmhm'.
Use of punctuation	Mindful use as can change meaning of spoken data.
Emphasis	When participant emphasises a word, this is underlined. E.g. 'How <u>dare</u> she'
Reported speech	When a person provides an apparent verbatim account of the speech or thoughts of another person (or their own past speech). Signal using inverted commas, e.g. and she said 'I don't know what to think'.
Identifying information	Provide unmarked, appropriate alternatives to potentially identifiable information.

APPENDIX K - Excerpt from Annotated Transcript

The following two pages show a section of Amy's transcript. The notes provided below are to facilitate the reader in understanding the coding process:

The left hand column shows comments and codes relating to the schema mode that participants were currently being asked about. Codes and comments in the left hand column correspond to interview data highlighted in green. Codes and comments are categorised according to the matrix column headings (e.g. 'contributing factors', 'responses').

The right hand column shows codes and comments which correspond to interview data where text colour has been changed to blue. Codes and comments in this column relate to other schema modes identified in the data (i.e. modes the participant was not currently being asked about).

Key: VC = Vulnerable Child mode, AC = Angry Child mode, DPP = Detached Protector Mode

571 her that I can't leave [name] because she's in a really bad way,
 572 even though she's thrown up on all my stuff. Cos I'm the sober
 573 one. Only recently I've started drinking alcohol again because
 Contributing 574 the consultant said five years at least. But anyway, this girl, she
 (AC) – others 575 put her hands on me and I said 'get your fucking hands off me'.
 as threatening 576 That's alright to say that but because I said it so sternly, she
 577 went back as if I had hit her. And then the same with my auntie
 Contributing 578 on holiday. She put her fucking hands on me, pinching like that
 (AC) – sense of 579 [demonstrates on self] and then the family are like as if I'm her.
 injustice 580 And its because I get angry and I'm like 'get your fucking hands
 581 off me' but what's wrong with that? They're all fucking drunk <I:
 Experience 582 yeah>. I'm the only one that didn't drink. And then I get the
 (AC) - Anger as 583 blame like 'oh, the way you acted'. As if they know what I'm
 justified/neces 584 gonna do!
 sary, others' 585 I: Uh-hu, yeah. So, do you feel like this does apply to you ever?
 responses as 586 P: No.
 blaming? 587 I: No.
 Experiences 588 P: No. Well I get angry and I scare people with my anger but I
 (AC) - Anger as 589 don't touch anyone. They do it to me.
 justified 590 I: Yeah. So maybe you feel the emotion but not doing the action
 591 if you like?
 592 P: Maybe I'm scary with the way I say it. Cos there was this one
 593 guy, who kept calling me a snitch. And I know if you get called
 594 that in prison then you're dead. But he overheard a
 595 conversation... He's a coward you see <I: uh-hu>. And I said to
 596 him... Because his sister who's just had the baby came over to
 597 me like that in my face [moves head forward] and I said to him,
 Contributing 598 next time I fucking... Sorry. Next time I see you I'm going to
 (AC) - Feeling 599 knock your fucking block off. And that fucking scared him. <I:
 victimised and 600 Hmmm>. I wouldn't do that but, just, he's a coward. To let his
 under threat 601 sister who's just had a baby to come and attack me. Arsehole.
 602 So there are anger issues.
 603 I: And what other kinds of things might trigger anger off for you?
 604 P: Family. You know I told you about my sister where I was
 Contributing 605 going to go for dinner? <I: yeah> And I said to her, cos she kept
 (AC) - Feeling 606 'arghhh', so I said to her 'and you're fucking perfect are you?'
 mistreated/put 607 And because I dropped the f-bomb I'm in the wrong. Even
 down by 608 though she dropped the f-bomb a few years ago first... Cos my
 others 609 mums got a real thing about swearing <I: right>. So I'm
 Experience 610 swearing like a trooper when I'm angry.
 (AC) – anger as 611 I: Right, yeah. Umm, so family stuff. Anything else? Is there a
 giving power? 612 recent example of where you've felt quite angry inside?
 613 P: Yeah. I was quite angry with my boyfriend. Cos he said that
 614 he would call. He left me hanging, hours, and then he had the

Experience
 (VC) – feeling
 neglected by
 others?

Contributing (AC) - Neglect from others	615	cheek to just like email me 'oh, like I'm too tired'. What the fuck.	
	616	Just call me and say that!	
	617	I: Uh-hu. And then what did you do?	
	618	P: I dumped him. [laughs]	
Experience (AC) – uncontrolled/i mpulsive rejection of others	619	I: You dumped him? Straight away or, how did it...	Response (VC – rejection of others
	620	P: I hate, I hate, I hate that word 'dumped' but I emailed 'duh-	
	621	duh-duh'. Uh, I don't even remember what I said, but it was	
	622	clear and to the point.	
	623	I: What was the feeling then? When you got that email?	
	624	P: It was... Argh. I was just... Cos I got the email after. I was	Response (VC – Reactive /impulsive response to neglect ?
	625	waiting for him. I was like 'argh'. Cos all he had to do was call	
	626	me up and say I'm tired. That's it. Not keep me waiting. And	
	627	then I left the house and went gallivanting until about two in the	
	628	morning. I put myself at risk.	
	629	I: And when did that happen?	overcompensating mode
	630	P: About two days ago.	
	631	I: Right. And how intense was that angry feeling?	
	632	P: Yeah. Well. I was just like 'arrrrrgghhh' Yeah. [sighs].	
	633	I: Yeah, OK. And then you sent the email and.../	
	634	P: Well I sent two emails.	
	635	I: You sent two emails?	
	636	P: Yeah. I cemented the fact I can't be doing with this. ↓ You've	Response (VC – anger towards others, demanding fi treatment (links between AC and VC?)
	637	got to be a man of your word or just don't say it [raising voice]	
	638	Because he knows I'm feeling vulnerable right now.	
	639	I: Yeah.	
	640	P: He says to me, which is funny, 'yeah but I talk to many times	
	641	a day'	
	642	I: And how long might that feeling last?	
	643	P: Twenty minutes. And then it comes back again.	
	644	I: What makes it stop and then start again do you think? What's	Experience (DPP) – using distraction as way of coping with anger
	645	going on there?	
	646	P: Just distract myself.	
Response (AC) - distraction	647	I: Oh, OK. So you can kind of distract yourself from the anger	
	648	and then it comes back in?	
	649	P: No, not the anger so much. Yeah. The anger actually.	
Contributing (AC) – thoughts about mistreatment from others	650	Because I think about what I've let people get away with and it	
	651	makes me angry.	
	652	I: OK.	
	653	P: But never violent.	
	654	I: Yeah. OK.	
	655	P: I'm angry with myself mostly.	
	656	I: Mmmm. Can you say more about why that is?	

APPENDIX L - Mode Descriptions (used to assist coding process) (From Young and First, 2003)

INNATE CHILD MODES

- 1. Vulnerable Child:** feels lonely, isolated, sad, misunderstood, unsupported, defective, deprived, overwhelmed, incompetent, doubts self, needy, helpless, hopeless, frightened, anxious, worried, victimized, worthless, unloved, unlovable, lost, directionless, fragile, weak, defeated, oppressed, powerless, left out, excluded, pessimistic
- 2. Angry Child:** feels intensely angry, enraged, infuriated, frustrated, impatient because the core emotional (or physical) needs of the vulnerable child are not being met
- 3. Impulsive/Undisciplined Child:** acts on non-core desires or impulses in a selfish or uncontrolled manner to get his or her own way and often has difficulty delaying short-term gratification; often feels intensely angry, enraged, infuriated, frustrated, impatient when these non-core desires or impulses cannot be met.; may appear “spoiled”
- 4. Contented Child:** feels loved, contented, connected, satisfied, fulfilled, protected, accepted, praised, worthwhile, nurtured, guided, understood, validated, self-confident, competent, appropriately autonomous or self-reliant, safe, resilient, strong, in control, adaptable, included, optimistic, spontaneous

MALADAPTIVE COPING MODES

- 5. Compliant Surrenderer:** acts in a passive, subservient, submissive, approval-seeking, or self-deprecating way around others out of fear of conflict or rejection; tolerates abuse and/or bad treatment; does not express healthy needs or desires to others; selects people or engages in other behavior that directly maintains the self-defeating schema-driven pattern
- 6. Detached Protector:** cuts off needs and feelings; detaches emotionally from people and rejects their help; feels withdrawn, spacey, distracted, disconnected, depersonalized, empty or bored; pursues distracting, self-soothing, or self-stimulating activities in a compulsive way or to excess; may adopt a cynical, aloof or pessimistic stance to avoid investing in people or activities
- 7. Overcompensator:** feels and behaves in an inordinately grandiose, aggressive, dominant, competitive, arrogant, haughty, condescending, devaluing, overcontrolled, controlling, rebellious, manipulative, exploitative, attention-seeking, or status-seeking way. These feelings or behaviors must originally have developed to compensate for or gratify unmet core needs.

MALADAPTIVE PARENT MODES

- 8. Punitive Parent:** feels that oneself or others deserves punishment or blame and often acts on these feelings by being blaming, punishing, or abusive towards self or others. This mode refers to the style with which rules are enforced rather than the nature of the rules.
- 9. Demanding or Critical Parent:** feels that the “right” way to be is to be perfect or achieve at a very high level, to keep everything in order, to strive for

high status, to be humble, to put others' needs before one's own or to be efficient or avoid wasting time; or the person feels that it is wrong to express feelings or to act spontaneously. This mode refers to the nature of the internalized high standards and strict rules, rather than the style with which these rules are enforced; these rules are not compensatory in their function.

APPENDIX M - Cohen's Kappa Calculations

Cohen's Kappa is used to assess inter-rater reliability when coding qualitative variables. Kappa has a range from 0-1.00. Larger values indicate better reliability. A Kappa > .70 is considered satisfactory.

This research required the identification of schema modes from transcripts. The complexity of modes (i.e. the combinations of thoughts, feelings and behaviours that are thought to represent them) mean that they can be difficult to distinguish from one another. Kappa was used to assess the inter-rater reliability of the mode identification process. The modes were abbreviated to Punitive Parent = PP, Demanding Parent = DP, Vulnerable Child = VC, Angry Child = AC, Impulsive Child = IC, Compliant Surrender = CS, Detached Protector = DPr and Overcompensator = OC.

16 extracts of transcript were rated by myself and a researcher conducting a similar project. Each of the 16 quotes were entered into a contingency table. Agreements between us (the two raters) were placed in diagonal cells. For example, we both identified quote 12 as OC, therefore this was tallied into the lower-right diagonal cell. Disagreements were placed in one of the off-diagonal cells. For example, rater #1 thought quote 9 was IC but rater #2 thought it was OC, so this was tallied into the middle column of the last row. Below is the result of tallying the ratings of each quote by each rater.

		Rater 1								Row totals
		PP	DP	VC	AC	IC	CS	DPr	OC	
Rater 2	PP	2								2
	DP		2							2
	VC			2						2
	AC				2					2
	IC									0
	CS						2			2
	DPr							2		2
	OC					2			2	4
Column totals		2	2	2	2	2	2	2	2	Overall total = 16

The overall total was calculated, ensuring that both row and column totals summed to the same value and the overall total was equal to the number of data extracts rated. The values in the diagonal cells were then summed to calculate the overall agreement rating.

$$\Sigma a = 2 + 2 + 2 + 2 + 2 + 2 + 2 = 14$$

Based on this, the % agreement was $14/16 = 87.5\%$. The expected frequency for the number of agreements that would have been expected by chance were computed for each coding category. This was done by applying the formula used for computing expected frequencies for Pearson's X^2 to the diagonal cells. Computation of the expected frequency of agreements by chance for the punitive parent mode is shown. Below that is the contingency table with the expected frequencies in each of the diagonal cells.

$$ef = \frac{\text{Row total} * \text{Column total}}{\text{Overall total}} = \frac{2 * 2}{16} = 0.25$$

		Rater 1							
Rater 2	PP	0.25							
	DP		0.25						
	VC			0.25					
	AC				0.25				
	IC					0			
	CS						0.25		
	DPr							0.37	
	OC								0.5

The computed sum of expected frequencies of agreement by chance was:

$$\Sigma ef = 0.25 + 0.25 + 0.25 + 0.25 + 0 + 0.25 + 0.37 + 0.5 = 1.87$$

Kappa was then computed:

$$K = \frac{\Sigma a - \Sigma ef}{N - \Sigma ef} = \frac{14 - 1.87}{16 - 0.25} = 0.77$$

Kappa was greater than .70 and therefore satisfactory.

APPENDIX N - Table of Quotes, Codes and Themes for the Punitive Parent Mode

NB: No sub-themes were identified for this mode by the end of the analytic process

Themes	Codes	Quotes
Blame over past regrets	Despairing over ruining chances	Just analysing myself and just in despair at all the chances that I've had and that I've blown away (26-28) (p3)
	Self-criticism revolves around following dreams and this not working out	Just thinking about not having, you know... just taken up any old job and just carrying on. You know, always having to be a dreamer and an eccentric and then ruining those chances too' (85-88) (p3)
	Blaming self for relapse and not completing degree	'I'm the one that relapsed and went into hospital and didn't finish my degree.' (378-382) (p3)
	Hates self when thinks about past regrets	Ummm, its all about the things that I have done in the past. I regret them and I'm wishing not to have them. Errr and umm and I'm, at that moment, I err I hate myself basically [.]. (12-14) (p2)
	Regrets past decisions	'...I don't umm you know, really like, um, really respect the decisions that I've made in life (936-940) (p1)
	Guilt and dislikes self for past treatment of mum	I have a bit of guilt around my mum. You know, not really thinking about how lonely she might of felt or sort of unable to cope and erm, so, I dislike that about myself (14-16) (p1)
	Regrets treatment of sister, feels deserving of hard life	'Because I was so cruel to my sister growing up. I think I said to her one time 'that's why I think I've had the life I've had' (229-231) (p7)
	Continues to feel guilt over past treatment of others	I always feel so guilty for that. I was nasty to her sometimes (64-65); Because I was really terrible and I didn't mean to (74) (P7)

	<p>Thinks about having let family down</p> <p>Ruminating over past regrets</p> <p>Blames self for not saying no</p>	<p>'....it feels that I've wasted my life and by doing that, I've not given my family all the things that they deserve. So, its effecting them too [crying] (34-36); 'They don't have a lovely big house and, you know, with a garden or a shed where the boys can do their experiments and stuff. I feel like I've let them down. Yeah [3]. (80-82)' (p3)</p> <p>'...Oh, just obsessing over things that you can't change and maybe desperately trying to to imagine what your life might have been like if you had made the right choices' (75-78) (p1)</p> <p>...sometimes if something happens around me that is nothing nice I always go back to the same place <mmm>. 'Why I didn't say no to my mum and errr not get married and do whatever I like to do?' (47-57) (p5)</p>
Self-attack	<p>Criticises appearance</p> <p>Shame over appearance</p> <p>Feels worthless according to society's standards</p>	<p>So I don't, just in general I don't feel good or like attractive. (24-25), It's always so negative. You know, like, oh, my skins really bad or my face looks fat. Or you know, my hair looks horrible. (35-37) (P6);</p> <p>'...I've become embarrassed to see someone I know because they're going to look at me and go 'oh god, hasn't she let herself go?' All the things.. And I'm going to sense what they're... And it's just going to reassure what I'm actually thinking and feeling <yeah>' (170-175) (p6)</p> <p>I Just feel, you know, if you know how it feels to feel worthless? I don't feel like I've achieved much in my life. You know, I've got lovely kids and a great family. But you're not weighed by those things in this</p>

		society. Your worth isn't measured by those things. (335-339). (p3)
	Thinks that she's stupid and won't achieve.	I just feel, that I'm stupid, I'm no good you know, or I'm never going to do anything with my life. I'm never going to achieve anything. Yeah, it's just horrible.' (301-305) (p6)
	Criticising self for not doing 'well'	Yeah, just again its like... there must be something wrong with me. Well, there is something wrong with me. I have brain damage and Bipolar. The two B's. Not in A-levels though. I got one B. (378-381) (p7)
	Thinks that she's stupid	And you know, there's other times where I feel like, you know, I'm not [...]... I erm, can't remember anything; I can't remember any facts, I must be stupid, you know, that kind of thing. (19-22) (p1)
	Feels like an embarrassment to others	I start thinking 'god, I should be doing this [watching TV] when I'm retired not now' 'I'm a bum' 'I'm an embarrassment to my family', all sorts. (249-253) (p7)
	Feels like a drain on society	Yeah. I just like, I feel like I'm a bum and a drain on society (12) (p7)
	Gets upset and blames self for lack of success.	I get very stressed and upset that 'oh what's wrong with me' and not very successful in life (13-15) (p7)
	Feels like a failure	I failed that [nursing]. I'm just always a failure (277-279) (p7)
	Critical thoughts come in a wave	'....you start dredging up a whole load of other stuff don't you? To be critical about yourself. And it does seem to come in a whole bit of a wave' (62-65) (p1)
	Self critical thoughts as consuming	Well you know, it [self criticising] makes me more introverted. So not outward looking. Not looking at what I could be, enjoying that day, or, you know [...] in life itself. Just focusing on

		<p>the misery basically. It's like scratching a scab isn't it? (72-75). (p1)</p> <p>It just goes into spirals [critical thoughts]. It just goes worse and worse and worse and worse. And its like I'm in hell <hmmm>. Just laying there in hell. It's awful (88-90) (p6)</p> <p>In my mind, I feel like I've done something or I've made myself look silly, because I feel so low about myself. I'm always critical about myself. (95-97) (p6)</p> <p>So it's been a constant theme throughout my life that I get opportunities and people give me a bit of leeway on stuff and then I take it to the maximum and then I kind of you know, I let myself down. And I let others down (372-375) (p7)</p> <p>I feel like I self sabotage a lot. I cut my nose off to spite my face and then I have recriminations and just feel even shitter about myself. So it's a never ending cycle (366-368) (p7)</p> <p>'When you get drunk you might say things or do things that you wouldn't normally do. So I lay in bed thinking 'oh god'. Like recording back to everything and my mind is going [round and around] (79-82)' (p6)</p> <p>I'm always either showing someone up or showing off. Umm, yes. I: And what do you think that's about? P: 'Deep down don't feel like I deserve it. I feel I don't deserve to do well, or, umm, to get good things or.... I always have to go and fuck up. (17-21) (p3)</p>
	Self-criticism spiralling	
	Always critical of self/feels like an embarrassment	
	Behaviour perpetuates feeling badly about self	
	Self-sabotaging perpetuates self attack	
	Ruminating on past behaviour perpetuates feeling badly about self	
	Self-sabotaging perpetuating self-attack	

	<p>Putting self in danger as punishment</p> <p>Neglecting self as punishment</p>	<p>I: Putting yourself in harms way? Ummm and which part of this would that be related to? P: Well it's about punishing myself. Because I deserve to have acid thrown in my face. (212-215) (p7)</p> <p>And then I don't eat that well and I start getting takeaways maybe or just not eating at all <I: Uh-hu>. So self neglect really. Which is another form of punishment isn't it?' (193-196) (p7)</p>
Perceived relationship to low mood	<p>Thinks badly of self when low</p> <p>Dislikes self because feeling low</p> <p>Mode is a symptom of depressed state</p> <p>Despairing with self because of low mood</p> <p>Thinking about past regrets fuels depressed mood</p> <p>Depression as a trigger for self-critical thoughts</p>	<p>when I'm low I just feel really shit about myself and its just like 'oh, I'm a terrible human being' 'no one wants to know me' (391-394) (P7)</p> <p>Umm I just dislike myself at the moment. I think just because I feel a bit low (5-6) (p6)</p> <p>I think its just a symptom of your depressive state (699) (p4)</p> <p>Well at the moment, I think because I'm a bit low, its just despairing with myself (24-25) (p3)</p> <p>That kind of follows on to other, you know, everything else do and not following my erm ambitions or not following through with love affairs and that kind of thing. And feeling a lot of regret basically. And then that becomes quite depressing (48-51) (p1)</p> <p>'...I tend to have that period of depression before going high. So that could be a trigger for it as well; feeling bad and dislike myself most of the time' [reading from mode card] (92-94) (p1)</p>

APPENDIX O - Matrix Template

A template was created for each mode. Quotes were organised per mode according to the headings.

Participant	Contributing factors (including internal and external triggers, childhood experiences)	Experience of mode (associated thoughts, images, feelings, memories, frequency, duration etc)	Responses to mode (e.g. coping, how does it stop)	Relationship between mode and mood state?
Sharon				
Zehra				
Eymen				
Michael				
Basima				
Lucy				
Amy				